DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Physician Services, Section 8.200
Rule Number: MSB 19-05-06-A
Division / Contact / Phone: Health Programs Office / Russ Zigler 303-866-5927 / Richard Delaney 303-866-3436

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 19-05-06-A, Revision to the Medical Assistance Rule concerning Physician Services, Section 8.200
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) 8.200, 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:	N/A
Is rule to be made permanent? (If yes, please attach notice of hearing).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.200 with the proposed text beginning at 8.200.1.A through the end of 8.200.3.C. This rule is effective January 10, 2021,

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Physician Services, Section 8.200
Rule Number: MSB 19-05-06-A
Division / Contact / Phone: Health Programs Office / Russ Zigler 303-866-5927 / Richard Delaney 303-866-3436

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 rule revision authorizes non-physician providers to provide health education services under general supervision of a provider authorized to supervise them under Colorado Department of Regulatory Agencies (DORA) rules. Health education services are added to the physician services definition section as "the provision of counseling, referral, instruction, suggestions, and support to maintain or improve health." The rule revision also authorizes physical therapy assistants, occupational therapy assistants, and speech language pathology clinical fellows to provide services within their scope of practice if under the general supervision of an enrolled provider authorized to supervise them under DORA rules. Finally, the rule revision authorizes speech language pathology assistants to provide services within their scope of practice under the direct supervision of a licensed speech language pathologist authorized to supervise them under DORA rules. The rule revision also replaces a reference to the outdated Immunization Services Benefit Coverage Standard with a citation to the Immunization rule section at 8.815. Finally, a regulatory citation correction is included as well.

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. §§ 1396d(a)(6), (a)(13) (2019); 42 CFR §§ 440.60, .130(c) (2019)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   25.5-5-102(d), C.R.S. (2019)

Initial Review	**10/09/20**	Final Adoption	**11/13/20**
Proposed Effective Date	**12/30/20**	Emergency Adoption	

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Physician Services, Section 8.200
Rule Number: MSB 19-05-06-A
Division / Contact / Phone: Health Programs Office / Russ Zigler 303-866-5927 / Richard Delaney 303-866-3436

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.

   Non-physician providers, physical therapy assistants, occupational therapy assistants, speech language pathology clinical fellows, and speech language pathology assistants will be affected by the proposed rule by authorizing them to render services if under appropriate supervision in accordance with DORA rules. The newly authorized providers, and the Health First Colorado (Colorado Medicaid) clients they serve, will benefit from the proposed rule. The Department bears the cost of reimbursing the newly authorized providers. Health First Colorado clients benefit from the addition of health education services, which target prevention and remediation of chronic health conditions like diabetes.

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

   Quantitative impact of the proposed rule is extending health education services to Health First Colorado clients and authorizing additional providers to render such services if under appropriate supervision in accordance with DORA rules. The rule also expands the list of authorized providers for physical therapy, occupational therapy, and speech language pathology, if such providers are under appropriate supervision in accordance with DORA rules. The qualitative impact is improving access to such services, and expanding the list of eligible providers, for Health First Colorado clients.

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 does not anticipate any costs related to allowing non-physician providers, physical therapy assistants, and occupational therapy assistants to provide health education services and therapy services under general supervision of an enrolled provider. No costs are estimated as non-physician providers, physical therapy assistants, and occupational therapy assistants currently are able to provide services under direct supervision, and these changes would lead to a substitution of direct

supervised services, and generally supervised services. The Department will pay the same rate for generally supervised services compared to directly supervised services, therefore there will be no fiscal impact.

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

   The probable benefit of implementing this rule revision is to increase access to health education services and physician services for Colorado Medicaid clients and to expand the list of providers eligible to render such services. The rule revision also replaces the outdated Immunization Services Benefit Coverage Standard incorporation by reference with a citation to the current Immunization Services rule. The costs of the proposed rule are reflected in the Department's cost estimates under item 3 above.

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 methods of achieving the purpose of the proposed rule.

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 achieving the purpose of the proposed rule.

8.200 PHYSICIAN SERVICES

8.200.1.A Definitions

1. Advanced Practice Nurse means a provider that meets the requirements to practice advanced practice nursing as defined in Article 38 of Title 12 of the Colorado Revised Statutes. In Colorado an Advanced Practice Nurse may have prescriptive authority.

2. Certified Family Planning Clinic means a family planning clinic certified by the Colorado Department of Public Health and Environment, accredited by a national family planning organization and staffed by medical professionals licensed to practice in the State of Colorado, including but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants, and advanced practice nurses.

3. Direct Supervision means the supervising provider shall be on-site during the rendering of services and immediately available to give assistance and direction throughout the performance of the service.

4. General Supervision means the supervising provider may not be on-site during the rendering of services, but is immediately available via telephonic or other electronic means to give assistance and direction throughout the performance of the service.

5. Health Education Services means the provision of counseling, referral, instruction, suggestions, and support to maintain or improve health.

~~5.~~6. Licensed Psychologist means a provider that meets the requirements to practice psychology as defined in Part 3 of Article 43 of Title 12 of the Colorado Revised Statutes.

~~6.~~7. Medical Necessity is defined in ~~10 C.C.R. 2505-10,~~ Section 8.076.1.8.

8.200.2 Providers

8.200.2.C. Physician services that may be provided by a non-physician provider when ordered by a provider acting under the authority described in Sections 8.200.2.A. and 8.200.2.B.

1. Registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed physician assistants may provide services ordered by a physician.

   a. Services must be rendered and supervised in accordance with the scope of practice for the non-physician provider described in the Colorado Department of Regulatory Agencies rules.

2. Licensed pharmacists, in accordance with the scope of practice for pharmacists as described in the Colorado Department of Regulatory Agencies rules 3 CCR ~~749~~719-1 and C.R.S. 12-42.5-101 et. seq., may provide covered services.

8.200.2.D. Physician services that may be provided by a non-physician provider when supervised by an enrolled provider.

1. With the exception of the non-physician providers described in Sections 8.200.2.A. through 8.200.2.C. and 8.200.2.D.1.a., a non-physician provider may provide covered goods and services only under the Direct Supervision of an enrolled provider who has the authority to supervise those services, according to the Colorado Department of Regulatory Agencies rules. If Colorado Department of Regulatory Agencies rules do not designate who has the authority to supervise, the non-physician provider must provide services under the Direct Supervision of an enrolled physician.

   a. Registered Nurses (RNs) are authorized to provide delegated medical services within their scope of practice as described in the Colorado Department of Regulatory Agencies rules under General Supervision.

   b. Non-physician providers are authorized to provide Health Education Services under General Supervision of a provider who has the authority to supervise them~~,~~ in accordance with Colorado Department of Regulatory Agencies rules.

   c. Physical therapy assistants, occupational therapy assistants, and speech language pathology clinical fellows are authorized to provide services within their scope of practice, and under the General Supervision of an enrolled provider who has the authority to supervise them, in accordance with Colorado Department of Regulatory Agencies rules.

   d. Speech language pathology assistants are authorized to provide services within their scope of practice only under the Direct Supervision of a licensed speech language pathologist who has the authority to supervise them, in accordance with Colorado Department of Regulatory Agencies rules

8.200.3. BENEFITS

8.200.3.A Physician services are reimbursable when the services are a benefit of Medicaid and meet the criteria of Medical Necessity as defined in ~~10 C.C.R. 2505-10,~~ Section 8.076.1.8 and are provided by the appropriate provider specialty.

1. Physician services in dental care are a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fraction of the jaw or facial bones. Service includes dental splints or other devices.

2. Outpatient mental health services are provided as described in ~~10 CCR 2505-10,~~ Section 8.212.

3. Physical examinations are a benefit when they meet the following criteria:

   a. Physical examinations are a benefit for preventive service, diagnosis and evaluation of disease or early and periodic screening, diagnosis and treatment for clients under the age of 21 as described in ~~10 C.C.R. 2505-10,~~ Section 8.280.

   b. Physical examination as a preventive service for adults is a benefit limited to one per state fiscal year.

4. Physician services for the provision of immunizations are a benefit. Vaccines provided to enrolled children that are eligible for the Vaccines for Children program shall be obtained through the Colorado Department of Public Health and Environment. Immunization services are provided in accordance with Section 8.815.

5. Physician services for laboratory testing described in ~~10 C.C.R. 2505-10,~~ Section 8.660, are a benefit.

6. Occupational and physical therapy services are benefits.

7. Family planning services described in ~~10 C.C.R. 2505-10,~~ Section 8.730 are benefits.

8.200.3.C Services and goods generally excluded from coverage are identified in ~~10 C.C.R. 2505-10,~~ Section 8.011.11.

~~8.200.3.C.2 Immunization Services Benefit Coverage Standard~~

~~All providers of vaccines through the Vaccines for Children program or the Colorado Immunization Program shall be in compliance with the Colorado Medicaid Immunization Services Benefit Coverage Standard (approved April 2, 2012), incorporated by reference. The incorporation of the Immunization Services Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.~~

~~The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to §24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Nursing Facility Minimum Wage Supplemental Payment, Section 8.443
Rule Number: MSB 20-03-31-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

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 20-03-31-A, Nursing Facility Minimum Wage Supplemental Payment

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) 8.443, 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 8.443 with the revised text beginning at 8.443.21 through the end of 8.443.21. This rule is effective January 10, 20121,

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Nursing Facility Minimum Wage Supplemental Payment, Section 8.443
Rule Number: MSB 20-03-31-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

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).

   House Bill (H.B.) 19-1210 authorizes local governments (towns, cities, counties) to establish a local minimum wage above the statewide minimum wage. The bill also establishes a new payment to nursing homes within a local government increasing their minimum wage above the statewide minimum wage. The new payment reimburses nursing homes for the increase in wages up to the locally enacted minimum wage, limited by Medicaid utilization. The rule establishes the new minimum wage supplemental detailing what nursing homes are eligible for the payment and the payment calculation methodology.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

   25.5-5-206, C.R.S.

Initial Review	**10/09/20**	Final Adoption	**11/13/20**
Proposed Effective Date	**12/30/20**	Emergency Adoption	

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Nursing Facility Minimum Wage Supplemental Payment, Section 8.443
Rule Number: MSB 20-03-31-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

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.

   Nursing homes will benefit from the proposed rule with a new supplemental payment to offset the increase in wages. Currently, Denver is the only local government to increase their minimum wage. Approximately 60 nursing homes in the Denver metro area are eligible to receive this payment. The state and federal governments will bear the costs of the proposed rule by funding the supplemental payment to nursing homes.

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 payment to nursing homes in the Denver metro area is projected to equal approximately $1.2 million in state fiscal year (SFY) 2020-21 for Denver's minimum wage increase to $12.85 on January 1st, 2020 and projected to equal approximately $3.94 million in SFY 2021-22 for a wage increase to $14.77 on January 1st, 2021. This payment will be used to offset the mandatory increase in employee wages up to the local minimum wage for Colorado nursing homes, limited by Medicaid utilization.

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 projected state funding obligation is approximately $.6 million for SFY 2020-21 and $1.97 million for SFY 2021-22. Additional costs include increased administration burden on Department staff to collect detailed payroll journal data from all eligible nursing homes to calculate the supplemental payment at least annually.

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

   The benefit of this rule include additional reimbursement to nursing homes to offset the mandatory increase in employee wages pursuant to H.B. 19-1210. The cost of

this rule include additional administration burden on Department staff to collect detailed payroll journal data from all eligible nursing homes to calculate the supplemental payment at least annually. The cost of this rule also include an increased state funding obligation.

The cost of inaction include not being compliant with state statute and not reimbursing nursing homes for the mandatory increase in employee wages.

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

   There are no other methods that are less costly or intrusive that still achieve the purposed of the proposed rule.

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.

   No alternative methods were seriously considered by the Department to achieve the desired goal of the proposed rule.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.20 CLASS II AND CLASS IV NURSING FACILITY PROVIDER FEE

8.443.20.A. The Department shall charge and collect provider fees on services provided by all class II and class IV nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees and federal matching funds shall be used to sustain reimbursement for providing medical care under the state's medical assistance program for class II and class IV nursing facility providers.

1. Each class II and class IV nursing facility that is licensed in Colorado shall pay a fee assessed by the Department.

2. To determine the amount of the fee to assess pursuant to this section, the Department shall establish a fee rate on a per patient day basis.

    a. The total annual fees due for class II and class IV nursing facilities will be calculated such that they do not exceed the federal limits as established in 42 C.F.R. section 433.68(f)(3)(i)(A), or five percent of the total costs for all class II and class IV nursing facilities, whichever is lower. 42 C.F.R. section 433.68(f)(3)(i)(A) (2013) is hereby incorporated by reference. The incorporation of 42 C.F.R. section 433.68(f)(3)(i)(A) excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

    b. The total annual fees will be divided by annual patient days for class II and class IV facilities from the most recently available MED-13 cost reports to establish the per patient day fee.

    c. The Department may use estimated patient days in the per patient day fee calculation to adjust for expected changes in utilization.

    d. When final audited MED-13 cost reports are available, the Department will review the fees charged during each state fiscal year to ensure that the fee amount was less than five percent of the total costs for all class II and class IV nursing facilities five percent statutory limit. If the fees were greater than five percent of the total costs for all class II and class IV nursing facilities, the Department will retroactively adjust the fees.

3. The Department shall calculate the fee to collect from each class II and class IV nursing facility by August 1 for the state fiscal year.

    a. The Department shall notify the providers of their fee obligation in writing at least 30 days prior to due date of the fee.

    b. The Department shall assess the provider fee on a monthly basis.

        i. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed to the Department.

ii. The monthly fee is due by last day of the month for which the fee was assessed

iii. Fees may be paid through intragovernmental transfer, Automated Clearing House, or check.

8.443.21 MINIMUM WAGE SUPPLEMENTAL PAYMENT

8.443.21.A The Department shall pay a supplemental payment to eligible class I nursing facility providers for the increase in hourly wages due to a local government increasing their minimum hourly wage above the statewide minimum hourly wage pursuant to section ~~C.R.S.~~ 25.5-6-208, C.R.S. ~~(2019).~~

1. At least once a year, the Department shall calculate the supplemental payment for an eligible class 1 nursing facility provider by multiplying each eligible employee's minimum hourly wage gap by the eligible employee's paid hours. The sum of this calculation for all eligible employees is multiplied by the eligible class 1 nursing facility provider's Medicaid utilization percentage.

   a. An eligible class 1 nursing facility provider resides within a local government that increases its minimum hourly wage above the statewide minimum hourly wage or resides within fifteen (15) driving miles of a class 1 nursing facility provider required to increase its minimum hourly wage above the statewide minimum hourly wage.

      i. A local government means any city, home rule city, town, territorial charter city, city and county, county, or home rule county.

   b. An eligible employee is an employee whose hourly wage increases to or above the local government minimum hourly wage when the local government minimum wage is enacted.

2. The minimum hourly wage gap is calculated as the difference between the enacted local government minimum hourly wage and the hourly wage for an eligible employee immediately before the local government minimum hourly wage is enacted.

   a. Hourly wages for an eligible employee include the base hourly wage and the overtime hourly wage.

   b. The overtime local government minimum hourly wage is limited to one and one-half times (1.5x) the local government minimum hourly wage.

   c. Hourly wages exclude any shift differential adjustments.

3. The paid hours include base, overtime, paid time off, and shift differential hours.

4. The Medicaid utilization percentage is a class 1 nursing facility provider's Medicaid patient days divided by total patient days.

   a. Medicaid patient days are determined using Medicaid paid claims for the most recent calendar year with at least four months of claims

runout. The Department shall annualize or estimate Medicaid patient days for class 1 nursing facility providers with less than a full year of paid claims.

b. Total patient days are reported by a class 1 nursing facility provider to the Department for the most recent calendar year with at least four months of claim runout. The Department shall annualize or estimate total patient days for class 1 nursing facility providers reporting less than a full year.

5. A class I nursing facility provider that resides within a local government that increases its minimum hourly wage above the statewide minimum hourly wage shall provide the Department with data necessary to calculate the supplemental payment. Class 1 nursing facility providers not providing the Department with data necessary to calculate the supplemental payment may not receive the supplemental payment.

6. A class I nursing facility provider that resides within fifteen (15) driving miles of a class I nursing facility provider required to increase its minimum hourly wage above the statewide minimum hourly wage, and that applies to the Department for the supplemental payment, shall provide documentation sufficient to prove that hourly wages have been increased in line with the adjacent local government minimum hourly wage. Class 1 nursing facility providers not providing the Department with data necessary to calculate the supplemental payment may not receive the supplemental payment.

~~1.~~7. The supplemental payment shall be limited by available appropriations. If the total supplemental payment for all eligible class 1 nursing facility providers is greater than available appropriations, the Department shall reduce all supplemental payments by a designated percent so that the total supplemental payment for all eligible class 1 nursing facility providers is less than or equal to available appropriations.

8. The submission of data for the calculation of the supplemental payment shall be considered the application for the supplemental payment. The submission of such data must include a statement by the licensed owner or corporate officer certifying that the data is true and accurate. Instructions for the data submission process will be communicated annually to all eligible class I nursing facility providers.

~~2.~~9. The Minimum Wage Supplemental Payment shall only be made if there is available federal financial participation under the Upper Payment Limit after all other Medicaid f~~F~~ee-for-service payments and Medicaid supplemental payments are considered.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning OP Pages, Section Form Review. Testing more copy here to see how it wraps.
Rule Number: MSB 20-08-19-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / John Lentz/303-866-3872

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 20-08-19-A, Revision to the Medical Assistance Act Rule concerning OP Pages, Section Form Review. Testing more copy here to see how it wraps.

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) 8.001.2.A., 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 at 8.001 with the proposed text beginning at 8.001.2.A through the end of 8.001.2.A. This rule is effective January 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning OP Pages, Section Form Review. Testing more copy here to see how it wraps.
Rule Number: MSB 20-08-19-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / John Lentz/303-866-3872

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 revision would exempt Durable Medical Equipment (DME) from all Electronic Visit Verification (EVV) requirements by removing DME from the list of services at section 8.001.2.A. of the rule

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:

   21st Century Cures Act, P.L. No. 114-255, Section 12006(a)

   CMS Informational Bulletin, “Additional EVV Guidance,” dated August 8, 2019

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

Initial Review	**10/9/2020**	Final Adoption	**11/13/2020**
Proposed Effective Date	**12/30/2020**	Emergency Adoption	

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning OP Pages, Section Form Review. Testing more copy here to see how it wraps.
Rule Number: MSB 20-08-19-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / John Lentz/303-866-3872

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Providers of durable medical equipment will be affected by this rule. They will be exempt from all EVV requirements. There are no costs associated with the exemption.

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

   The Department learned from DME providers that EVV records for DME would be impractical and have very limited use. The Department pays for each provider to use EVV records. For this reason, the cost of requiring EVV records for DME outweighs the benefits for both providers and the Department. This exemption will remove the administrative burden for providers and the cost to the Department.

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 is no cost associated with the implementation of this rule. The rule will reduce the cost to the Department of implementing the EVV requirements.

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

   The benefit of the proposed rule will be reduced administrative burden to providers and reduced cost to the Department to implement the federally mandated EVV requirements. The cost of inaction would be the implementation of requirements on DME providers that have little use to them or the Department, as well as the cost to the Department for each DME provider to use EVV records.

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 intrusive methods to achieve the purpose of the proposed rule.

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 making the proposed exemption for DME providers.

8.001 ELECTRONIC VISIT VERIFICATION (EVV)

8.001.1 Definitions

8.001.1.A. Alternate Location means any location entered into the EVV Record that was not automatically collected as a part of the EVV record.

8.001.1.B. Colorado Medicaid ID means the Colorado Medicaid identification number assigned to each Medicaid member by the Department.

8.001.1.C. Department means the Colorado Department of Health Care Policy & Financing.

8.001.1.D. Direct Care Worker means the person providing a service to a client. The Direct Care Worker may be an employee of a Provider.

8.001.1.E. Direct Care Worker ID means the last five digits of the Direct Care Worker's social security number.

8.001.1.F. Edited EVV Entry means an EVV record that has had any element modified via Visit Modification as defined in Section 8.001.3.C.1.b.

8.001.1.G. Electronic Visit Verification (EVV) means the use of technology, including mobile device technology, telephony, or Manual Visit Entry, to verify the required data elements related to the delivery of a service mandated to be provided using EVV by the "21st Century Cures Act," P.L. No. 114-255, or this rule.

8.001.1.H. Electronic Visit Verification Record (EVV Record) means a record of a visit recorded by an EVV System containing all data points in Section 8.001.3.A.1.b. of this rule.

8.001.1.I. Electronic Visit Verification System (EVV System) means the State EVV Solution or a Provider Choice System used by a Provider to comply with the EVV requirements in this rule.

8.001.1.J. Exception means a data integrity alert identified by the State EVV Solution or Provider Choice System.

8.001.1.K. Geo-fencing means the practice of utilizing a virtual perimeter in a geographic area.

8.001.1.L. Live-in Caregiver means a caregiver who permanently or for an extended period of time resides in the same residence as the Medicaid member receiving services. Live-in Caregiver status is determined by meeting requirements established by the U.S. Department of Labor, Internal Revenue Service, or Department-approved extenuating circumstances. Documentation of Live-in Caregiver status must be collected and maintained by Provider or Financial Management Services Vendor.

8.001.1.M. Manual Visit Entry means an EVV recorded after the time of service delivery, including all data elements as defined in Section 8.001.3.A.1.b.

8.001.1.N. Mobile Visit Verification Application (MVV Application) means a mobile device application that is used by the Direct Care Worker to record visit data at the start and end of the visit.

8.001.1.O. Provider means an actively enrolled Medicaid provider in good standing as defined in Section 8.076.

8.001.1.P. Provider Choice System means an alternative to the State EVV Solution made available by the Department. A Provider Choice System is provided by a Provider and satisfies all requirements as defined in this rule, is compatible with the State EVV Solution, and is consistent with Federal and State law.

8.001.1.Q. Provider EVV Portal means the web-based administrative tool used by Providers using the State EVV Solution to manage EVV activity and add Manual Visit Entry data elements and to monitor all activity recorded in the EVV System for Provider Choice Systems.

8.001.1.R. Reason Codes means standard codes established by the Department used to explain a Manual Visit Entry, Visit Modification, or acknowledge an Exception for missing required visit information.

8.001.1.S. State EVV Solution means the portion of the EVV System that manages data related to the visit and includes the MVV Application, TVV System, and the Provider EVV Portal made available by the Department.

8.001.1.T. Telephonic Visit Verification System (TVV System) means a toll-free telephone number system used by Direct Care Workers to record visit data at the start and end of a visit.

8.001.1.U. Threshold means the Departmentally-defined acceptable limit, determined as a percent, of EVV data recorded after the time of service delivery through Visit Modification or Manual Visit Entry.

8.001.1.V. Visit Modification means the edit of required visit data elements, as defined in Section 8.001.3.A.1.b, after the time of service delivery.

8.001.2 Provider Applicability

8.001.2.A. Providers of the following services reimbursed by the Department as fee-for-service must utilize EVV:

1. Behavioral Services when provided in the home or community, as defined in Sections 8.212, and 8.500.94.B.2, when provided in the home or community;

2. Consumer Directed Attendant Support Services as defined in Sections 8.510 and 8.500.90.I;

~~3. Durable Medical Equipment when provided in the home or community as defined in Sections 8.595 and 8.590;~~

4~~3~~. Home Health Services as defined in Section 8.520.1.K;

4~~5~~. Homemaker Services as defined in Sections 8.490.1 and 8.500.94.B.8;

5~~6~~. Hospice Services when provided in the home as defined in Section 8.550.1;

6~~7~~. Independent Living Skills Training as defined in Section 8.516.10.A.1;

7~~8~~. In-Home Support Services as defined in Sections 8.506.4.C and 8.552.1.M;

8~~9~~. Life Skills Training as defined in Section 8.553.1.H;

9~~10~~. Pediatric Behavioral Therapies provided under Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Services, when provided in the home or community as defined in Section 8.280;

10~~1~~. Pediatric Personal Care when provided in the home or community, as defined in Section 8.535.1;

11~~2~~. Personal Care Services provided as defined in Sections 8.489.10.11 and 8.500.94.B.13;

a. Personal Care Services provided in a Provider-owned residential type setting and paid via per diem are excluded from the EVV requirements outlined in this rule.

12~~3~~. Physical Therapy and Occupational Therapy when provided in the home or community as defined in Section 8.200.3.A.6;

13~~4~~. Private Duty Nursing as defined in Section 8.540.1;

14~~5~~. Respite when provided in the home or community, as defined in Sections 8.492.10.11 and 8.508.100.J;

15~~6~~. Speech Therapy when provided in the home or community, as defined in Section 8.200.3.D.2; and

16~~7~~. Youth Day Services when provided in the home or community as defined in Section 8.503.40.A.13.

8.001.3 Provider Responsibilities

8.001.3.A. The Department will make available the State EVV Solution to all Providers of services specified in Section 8.001.2.A. of this rule. The State EVV Solution will include an MVV Application, TVV System, and Provider EVV Portal.

1. The State EVV Solution made available by the Department must be used by all Providers except for Providers using a Provider Choice System pursuant to Section 8.001.3.B. of this rule. Providers using the State EVV Solution must do the following:

a. Utilize the MVV Application or the TVV System made available by the Department as the primary method for collecting visit data.

i. If the visit did not take place at the location captured by MVV or TVV, the Provider must indicate the actual visit location as an Alternate Location.

ii. If the MVV Application and TVV System are unavailable during an EVV visit, the Direct Care Worker and the Direct Care Worker's associated Provider, as applicable, are responsible for entering any uncaptured data elements for that visit via Manual Visit Entry. Manual Visit Entry must be used as the last alternative for recording the visit data.

b. Collect, for each visit, the following data:

i. The Colorado Medicaid ID of the client receiving the service;

ii. Information to identify the Direct Care Worker providing the service;

iii. The time the visit begins and ends;

iv. The EVV-required service performed;

v. The date the visit occurs; and

vi. The location of the visit.

8.001.3.B. The Department will allow all Providers of services specified in Section 8.001.2.A. of this rule to utilize a Provider Choice System.

1. Providers using a Provider Choice System must utilize an EVV Provider Choice System that satisfies all technical specifications as identified by the Department to:

a. Collect and submit to the Department, for each visit, the data elements contained in Section 8.001.3.A.1.b. of this rule;

i. When a Provider enters visit data via Manual Visit Entry, the Provider Choice System must indicate that the data was entered manually.

ii. When a Provider modifies existing visit data, the Provider must indicate the reason code for modification and enter reason code notes, if pertinent or required.

b. Utilize a Direct Care Worker ID for all individuals providing services to clients, as identified in Section 8.001.1.E. of this rule;

c. Identify all Exceptions using standard codes identified by the Department;

d. Utilize the Reason Codes identified by the Department;

e. Resolve any Exceptions noted in the State EVV Solution; and

f. Submit data to the State EVV Solution in a format and at a frequency identified by the Department.

2. A Provider Choice System must maintain compliance with the requirements identified in this rule, including incorporating into the system any changes in data requirements that must be transmitted to the State EVV Solution. It is the responsibility of providers using a Provider Choice System to ensure successful interaction between their Provider Choice System and the State EVV Solution.

3. Any costs related to the development of a Provider Choice System will not be the responsibility of the Department.

4. The Department will not provide training or support on the interaction of individual Provider Choice Systems with the State EVV Solution.

5. If a Provider is unable to obtain a compatible Provider Choice System, the Provider must use the State EVV Solution made available by the Department.

8.001.3.C. Visit Entry and Visit Modifications

1. All visit data points as defined in Section 8.001.3.A.1.b. must be completed at time of service delivery.

a. If a visit is entered administratively, and not by a caregiver at the time of service, the visit is considered a Manual Visit Entry.

b. If any data elements are edited after the time of service delivery, the edits are considered to be a Visit Modification resulting in an Edited EVV Entry.

2. Manual Visit Entries and Edited EVV Entries are subject to Department audit based on published Department Thresholds, in accordance with Section 8.076.

3. Providers must maintain all documentation required to substantiate the data elements required by Section 8.001.3.A.1.b of this rule to support Manual Visit Entries, Visit Modifications, and Exceptions. If this documentation cannot be maintained in the EVV System utilized by the Provider, the documentation must be maintained outside of the EVV System. The documentation must be made available to the Department or the Department's designee upon request, as required by Section 8.130.2.

4. Providers must resolve any Exceptions associated with Manual Visit Entries and Visit Modifications.

5. Exemptions

a. Live-in Caregivers who have completed Department required documentation are not mandated to collect EVV data, unless otherwise required by their Provider as defined by 8.001.1.O. of this rule.

i. Falsification or misrepresentation of information on Live-in Caregiver documentation may result in Department revocation of an individual's Live-in Caregiver exemption. If Live-in Caregiver exemption is revoked, the caregiver and provider must complete EVV pursuant to this rule.

6. EVV Record Restrictions

a. The Department will not allow or accept biometric data, pictures, video, or voice recordings to identify clients or substantiate Medicaid visit data.

i. Visit data that includes biometric data, pictures, video, or voice recordings is not required and must not be submitted.

b. The Department will not allow or accept visit data that includes continual GPS tracking during a visit. The Department will only accept location information at the beginning and/or end of a Medicaid visit.

i. Visit data that includes continual GPS tracking is not required and must not be submitted.

c. The Department will not utilize geo-fencing to restrict location of Medicaid service delivery.

i. Visit data that restricts location of service delivery using geo-fencing is not required and must not be submitted

8.001.3.D. Providers of the services specified in Section 8.001.2.A. of this rule must adhere to the following:

1. Comply with all provisions of this rule.

2. Use the State EVV Solution or a Provider Choice System to collect and maintain EVV data as required in Sections 8.001.3.A.1.b. and 8.001.3.B.1.a.

3. Consistent with Section 8.130, maintain a record of clients subject to EVV requirements to whom they are providing services and the required data elements pertaining to these clients. The required data elements include:

    a. Colorado Medicaid ID;

    b. Last name;

    c. First name;

    d. One known address at which the client may routinely receive services; and

    e. Telephone number.

4. Maintain a current list of Direct Care Workers who are providing services subject to EVV requirements to clients enrolled in Colorado Medicaid and the required data elements pertaining to the Direct Care Workers. The required data elements include:

    a. Last name;

    b. First name; and

    c. Direct Care Worker ID.

5. Maintain all documentation certifying the status of Live-in Caregivers providing services otherwise subject to EVV requirements set forth in this rule. Evidence of valid Live-in Caregiver status must be available upon Department request.

6. Utilize EVV for all services subject to the provisions of this rule.

7. Report any known or suspected falsification of EVV data to the Department within two business days of discovery.

8. Complete all required EVV training.

8.001.3.E. Compliance

1. Providers are required to comply with the requirements of this rule beginning on August 3, 2020.

    a. Providers that fail to comply with this rule after August 3, 2020 may be subject to Compliance Monitoring and a Request for Written Response in accordance with Section 8.076.

    b. Providers that fail to comply with this rule after October 1, 2020 may be subject to Compliance Monitoring, Request for Written Response, or Overpayment Recovery.

    c. Providers that fail to comply with this rule after January 1, 2021 may be subject to Compliance Monitoring, Request for Written Response, Overpayment Recovery,

Denial of Claims, Suspension, Termination, or Nonrenewal of their Colorado Medicaid Provider Agreement in accordance with Section 8.076.

2. If the Department determines that there is a credible allegation of fraud, the Provider may be subject to a Suspension of Payments in accordance with Section 8.076.4.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Personal Care and Homemaker Services, 8.489 and 8.490
Rule Number: MSB 20-08-19-C
Division / Contact / Phone: Benefits & Services Management / Kristine Dos Santos / 4416

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 20-08-19-C, Revision to the Medical Assistance Rule Concerning Personal Care and Homemaker Services, 8.489 and 8.490

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) 8.489 and 8.490, 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 8.489 with the proposed text beginning at 8.489.10 through the end of 8.489.50. Replace the current text at 8.490 with the proposed text beginning at 8.490.5 through the end of 8.490.5. Replace the current text at 8.516.10 with the proposed text beginning at 8.516.10.D through the end of 8.516.10.D. This rule is effective January 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Personal Care and Homemaker Services, 8.489 and 8.490
Rule Number: MSB 20-08-19-C
Division / Contact / Phone: Benefits & Services Management / Kristine Dos Santos / 4416

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).

   Revision to Personal Care and Homemaker Services Rules to strike language regarding travel time. This change is consistent with implementation of the Electronic Visit Verification (EVV), which complies with the federal definition of personal care service

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:

   "21st Century Cures Act," P.L. No. 114-255, 42 C.F.R. 440.167 “Personal Care Services"

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   10 CCR 2505-10 Section 8.001

Initial Review	**10/09/2020**	Final Adoption	**11/13/2020**
Proposed Effective Date	**12/30/2020**	Emergency Adoption	

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Personal Care and Homemaker Services, 8.489 and 8.490
Rule Number: MSB 20-08-19-C
Division / Contact / Phone: Benefits & Services Management / Kristine Dos Santos / 4416

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.

   Revision of Personal Care and Homemaker Services Rules 8.489 and 8.490 will affect providers currently billing for direct care worker travel time between member service visits for Personal Care and Homemaker services (offered under the Brain Injury, Community Mental Health Supports, Elderly, Blind & Disabled, and Spinal Cord Injury Waivers). Under Electronic Visit Verification and the federal definition of personal care services, billing of travel time is not contemplated.

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 travel time cannot be billed under Personal Care and Homemaker codes, providers who are currently billing for travel time will experience a decrease in reimbursement. To offset these costs, the Department has rebased the reimbursement rates.

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 received federal and state approval to rebase rates for impacted providers. The adjustment is expected to be cost neutral to the Department for both implementation and enforcement.

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

   Under EVV, travel time is not permitted to be billed under direct service codes. Technical Guidance from CMS indicates that travel time may not be billed as a service unit when service-specific tasks are not also being provided. The inaction of the Department could result in non-compliance with a federal mandate and open the Department up for significant disallowance risk.

DO NOT PUBLISH THIS PAGE

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

   There are no other methods for achieving the purpose of this proposed rule change.

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.

   No alternative methods were considered by the Department as revision of this rule is necessary to comply with a federal mandate.

8.489 PERSONAL CARE

8.489.10 DEFINITIONS

.11 Personal care services 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 as described in the EXCLUSIONS section below, do not require the supervision of a nurse, and do not require physician's orders.

.12 Personal care provider means a provider agency as defined at 10 CCR 2505-10 section 8.484.50.Q which has met all the certification standards for personal care providers listed below.

.13 Personal care staff means those employees of the personal care provider agency who perform the personal care tasks.

.14 Skilled personal care means skilled care which may only be provided by a certified home health aide, as further defined at 10 CCR 2505-10 section 8.522, and in the EXCLUSIONS section below.

.15 Unskilled personal care means personal care which is not skilled personal care, as defined above.

8.489.20 GENERAL PERSONAL CARE RULES

.21 Personal care services shall include unskilled personal care as defined under INCLUSIONS for each personal care task listed in 10 CCR 2505-10 section 8.489.30.

.22 EXCLUSIONS AND RESTRICTIONS

A. Personal care services shall not include any skilled personal care, which must be provided as home health aide services or as nursing services under non-HCBS programs. These services as defined under EXCLUSIONS for each personal care task listed in 10 CCR 2505-10 section 8.489.30, shall not be provided as personal care services under HCBS, regardless of the level of the training, certification, or supervision of the personal care employee.

B. Personal care staff shall not perform tasks that are not included under INCLUSIONS for each personal care task listed in 10 CCR 2505-10 section 8.489.30, or tasks that are not listed. For example, personal care staff shall not provide transportation services and shall not provide financial management services. Clients, family, or others may choose to make private pay arrangements with the provider agency for services that are not Medicaid benefits, such as companionship.

C. The amount of personal care that is prior authorized is only an estimate~~, including estimated travel time~~. The prior authorization of a certain number of hours does not create an entitlement on the part of the client or the provider for that exact number of hours. All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the client's needs.

D. Personal care provider agencies may decline to perform any specific task, if the supervisor or the personal care staff feels uncomfortable about the safety of the client or the personal care staff, regardless of whether the task may be included in the INCLUSIONS section for the task.

E. Family members shall not be reimbursed to provide only homemaker services. Family members must provide relative personal care in accordance with 10 CCR 2505-10 SECTION 8.485.200. Documentation of services provided must indicate that the provider is a relative.

8.489.30 SPECIFIC PERSONAL CARE TASKS

.31 The specific personal care tasks shall be authorized and provided according to the following rules.

A. BATHING

1. INCLUSIONS:

Bathing is considered unskilled only when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the bathing.

2. EXCLUSIONS:

Bathing is considered skilled when skilled skin care, skilled transfer or skilled dressing is required, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2. EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2, or EXCLUSIONS for dressing at 10 CCR 2505-10 section 8.489.31.G.2.

B. SKIN CARE:

1. INCLUSIONS:

Skin care is considered unskilled only when skin is unbroken, and when any chronic skin problems are not active. Unskilled skin care must be of a preventive rather than a therapeutic nature, and may include application of non-medicated lotions and solutions, or of lotions and solutions not requiring a physician's prescription; rubbing of reddened areas; reporting of changes to supervisor, and application of preventive spray on unbroken skin areas that may be susceptible to development of decubiti. Unskilled skin care does not include any of the care described under skilled skin care in the EXCLUSIONS section below.

2. EXCLUSIONS:

Skin care is considered skilled when there is broken skin, or potential for infection due to a chronic skin condition in an active stage. Skilled skin care includes wound care, dressing changes, application of prescription medications, skilled observation and. reporting, but does not include use of sterile technique.

C. HAIR CARE

1. INCLUSIONS:

Hair care is considered unskilled only when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the hair care. Hair care under these limitations may include shampooing with non-medicated shampoo or shampoo that does not require a physician's prescription, drying, combing and styling of hair.

2. EXCLUSIONS:

Hair care is considered skilled when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2. EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2. or EXCLUSIONS for dressing at 10 CCR 2505-10 section 8.489.31.G.2is required in conjunction with the hair care.

D. NAIL CARE

1. INCLUSIONS:

Nail care is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the nail care; and only in the absence of any medical conditions that might involve peripheral circulatory problems or loss of sensation. Nail care under these limitations may include soaking of the nails, pushing back cuticles, and trimming and filing of nails.

2. EXCLUSIONS:

Nail care is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the nail care; and in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation.

E. MOUTH CARE

1. INCLUSIONS:

Mouth care is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the mouth care. Mouth care under these limitations may include denture care and basic oral hygiene.

2. EXCLUSIONS:

Mouth care is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the mouth care; or when there is injury or disease of the face, mouth, head or neck; or in the presence of communicable disease; or when the client is unconscious; or when oral suctioning is required.

F. SHAVING

1. INCLUSIONS:

Shaving is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with shaving; and only an electric razor may be used.

2. EXCLUSIONS

Shaving is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with shaving.

G. DRESSING

1. INCLUSIONS:

Dressing is considered unskilled only when skilled skin care or skilled transfer, as described under EXCLUSIONS, is not required in conjunction with the dressing. Unskilled dressing may include assistance with ordinary clothing; application of support stockings of the type that can be purchased without a physician's prescription; application of orthopedic devices such as splints and braces, or of artificial limbs, if considerable manipulation of the device or limb is not necessary, and if the client is fully trained in the use of the device or limb and is able to instruct the personal care staff.

2. EXCLUSIONS:

Dressing is considered skilled when skilled skin care or skilled transfer, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 or EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2 is required in conjunction with the dressing. Skilled dressing may include application of anti-embolic or other pressure stockings that can be purchased only with a physician's prescription; application of orthopedic devices such as splints and braces, or of artificial limbs, if considerable manipulation of the device or limb is necessary, or if the client is still learning to use the device or limb.

H. FEEDING

I. INCLUSIONS:

Feeding is considered unskilled only when skilled skin care or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the feeding, and when oral suctioning is not needed on a stand-by or other basis. Unskilled feeding includes assistance with eating by mouth, using common eating utensils, such as forks, knives and straws.

2. EXCLUSIONS:

Feeding is considered skilled when skilled skin care or skilled dressing, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 or EXCLUSIONS for dressing at 10 CCR 2505-10 section 8.489.31.G.2 is required in conjunction with the feeding, and when oral suctioning is needed on a stand-by or other basis. Syringe feeding is also considered skilled. Feeding is skilled if there is a high risk of choking that could result in the need for emergency measures such as CPR or Heimlich maneuver.

I. AMBULATION

1. INCLUSIONS:

Assistance with ambulation is considered unskilled only when skilled transfers, as described under EXCLUSIONS, are not required in conjunction with the ambulation. In addition, when assisting a client with adaptive equipment, the client must be fully trained in the use of such equipment; and when assisting someone in a cast, there must be no need for observation and reporting to a nurse, and no need for skilled skin care, as described under EXCLUSIONS. Adaptive equipment may include, but is not limited to, gait belts, walkers, canes and wheelchairs.

2. EXCLUSIONS:

Assistance with ambulation is considered skilled when skilled transfers, as described under EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2 are required in conjunction with the ambulation. In addition, when assisting a client with adaptive equipment, it is considered skilled if the client is still being trained in the use of such equipment; and assisting someone in a cast is considered skilled there is a need for observation and reporting to a nurse, or if there is a need for skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2.

J. EXERCISES

1. INCLUSIONS:

Assistance with exercises is considered unskilled only when the exercises are not prescribed by a nurse or other licensed medical professional. Unskilled assistance with exercise is limited to the encouragement of normal bodily movement, as tolerated, on the par: of the client. Personal care staff shall not prescribe nor direct any type of exercise program for the client.

2. EXCLUSIONS:

Assistance with exercises is considered skilled when the exercises are prescribed by a nurse or other licensed medical professional. This may include passive range of motion.

K. TRANSFERS

1. INCLUSIONS:

Assistance with transfers is considered unskilled only when the client has sufficient balance and strength to assist with the transfer to some extent. Except for Hoyer lifts, adaptive equipment may be used in transfers, provided that the client is fully trained in the use of the equipment and can direct the transfer step by step. Adaptive equipment may include, but is not limited to, gait belts, wheel chairs, tub seats, grab bars.

2. EXCLUSIONS:

Assistance with transfers is considered skilled when the client is unable to assist with the transfer. Use of Hoyer lifts is considered skilled, and use of other adaptive equipment is considered skilled if the client is still being trained in the use of the equipment.

L. POSITIONING

1. INCLUSIONS:

Positioning is considered unskilled only when the client is able to identify to the personal care staff, verbally, non-verbally or through others, when the position needs to be changed; and only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the positioning. Positioning may include simple alignment in a bed, wheelchair, or other furniture.

2. EXCLUSIONS:

Positioning is considered skilled when the client is not able to identify to the caregiver when the position needs to be changed, and when skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the positioning.

M. BLADDER CARE

1. INCLUSIONS:

Bladder care is considered unskilled only when skilled transfer or skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the bladder care. Unskilled bladder care may include assisting the client to and from the bathroom; assistance with bedpans, urinals, and commodes; and changing of clothing and pads of any kind used for the care of incontinence. Emptying of Foley catheter bags or suprapubic catheter bags is considered unskilled only if there is no disruption of the closed system; the personal care staff must be trained to understand what constitutes disruption of the closed system.

2. EXCLUSIONS:

Bladder care is considered skilled whenever it involves disruption of the closed system for a foley or suprapubic catheter, such as changing from a leg bag to a night bag. Care of external catheters is also considered skilled.

N. BOWEL CARE

1. INCLUSIONS:

Bowel care is considered unskilled only when skilled transfer or skilled skincare, as described under EXCLUSIONS, is not required in conjunction with the bowel care. Unskilled bowel care may include assisting the client to and from the bathroom; assistance with bed pans and commodes; and changing of clothing and pads of any kind used for the care of incontinence. Emptying of ostomy bags and assistance with other client-directed ostomy care is unskilled only when there is no need for skilled skin care or for observation and reporting to a nurse.

2. EXCLUSIONS:

Bowel care is considered skilled when skilled transfer or skilled skin care, as described under EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2 or EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the bowel care. Skilled bowel care includes digital stimulation and enemas. Skilled bowel care may include care of ostomies that are new and care of ostomies when the client is unable to self-direct the care, provided that sterile technique is not required.

O. MEDICATION REMINDING

1. INCLUSIONS:

Medication reminding is allowed as unskilled personal care only when medications have been preselected, by the client, a family member, a nurse, or a pharmacist, and are stored in containers other than the prescription bottles, such as medication minders. Medication minder containers must be clearly marked as to day and time of dosage, and must be kept in such a way as to prevent tampering. 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 container for the client if the client is physically unable to open the container. Medication reminding does not include taking the medication out of the container. These limitations apply to all prescription and all over the counter medications, including pm medications. Any irregularities noted in the preselected medications, such as medications taken too often or not often enough, or not at the correct time as marked on the medication minder container, shall be immediately reported by the personal care staff to a supervisor.

2. EXCLUSIONS:

Medication assistance is considered skilled care and consists of putting the medication in the client's hand when the client can self-direct in the taking of medications.

P. RESPIRATORY CARE

1. INCLUSIONS:

Respiratory care is not considered unskilled. However, personal care staff may clean or change the tubing for oxygen equipment, may fill the distilled water reservoir, and may temporarily remove and replace the cannula or mask from the client's face for purposes of shaving or washing the client's face. Adjustments of the oxygen flow are not allowed.

2. EXCLUSIONS:

Respiratory care is skilled care, and includes postural drainage, cupping, adjusting oxygen flow within established parameters, and suctioning of mouth and nose.

Q. ACCOMPANYING

1. INCLUSIONS:

Accompanying the client to medical appointments, banking errands, basic household errands, clothes shopping, and grocery shopping to the extent necessary and as specified on the care plan is considered unskilled, when all the care that is provided by the personal care staff in relation to the trip is unskilled personal care, as described in these regulations. Accompanying the client to other services is also permissible as specified on the care plan, to the extent of time that the client would otherwise receive personal care services in the home.

Personal care for the purpose of accompanying the client shall only be authorized when a personal care provider is needed during the trip to provide one or more other unskilled personal care services listed in this Section. Accompanying the client primarily to provide companionship is not a covered benefit.

2. EXCLUSIONS:

Accompanying is considered skilled when any of the tasks performed in conjunction with the accompanying are skilled tasks. Accompanying does not include transporting the client.

R. HOMEMAKING

Homemaking, as described at 10 CCR 2505-10 section 8.490, may be provided by personal care staff, if provided during the same visit as unskilled personal care, as described in these regulations.

S. PROTECTIVE OVERSIGHT

1. INCLUSIONS:

Protective oversight is considered unskilled when the client requires stand-by assistance with any of the unskilled personal care described in these regulations, or when the client must be supervised at all times to prevent wandering.

2. EXCLUSIONS:

Protective oversight for standby assistance with personal care tasks is considered skilled if any of the tasks performed are skilled tasks. Protective oversight to prevent wandering is considered skilled if any skilled personal care tasks are performed while providing oversight.

.32 Personal care services as described above may be used to provide respite care for primary care givers, provided that the respite care does not duplicate any care which the primary caregiver may be receiving payment to provide.

8.489.40 CERTIFICATION STANDARDS FOR PERSONAL CARE SERVICES

.41 Personal care provider agencies shall conform to all general certification standards and procedures at 10 CCR 2505-10 section 8.487, HCBS-EBD PROVIDER AGENCIES, and shall meet all the additional personal care certification requirements in this section.

.42 Personal care provider agencies shall assure and document that all personal care staff have received at least twenty hours of training, or have passed a skills validation test, in the provision of unskilled personal care as described above. Training, or skills validation, shall include the areas of bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care, medication reminding, homemaking, and protective oversight. Training shall also include instruction in basic first aid, and training in infection control techniques, including universal precautions. Training or skills validation shall be completed prior to service delivery, except for components of training that may be provided in the client's home, in the presence of the supervisor.

.43 All employees providing personal care shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of personal care staff, as specified above. Supervision shall include, but not be limited to, the following activities:

A. Orientation of staff to agency policies and procedures.

B. Arrangement and documentation of training.

C. Informing staff of policies concerning advance directives and emergency procedures.

D. Oversight of scheduling, and notification to clients of changes; or close communication with scheduling staff.

E. Written assignment of duties on a client-specific basis.

F. Meetings and conferences with staff as necessary.

G. Supervisory visits to client's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, client-specific or procedure-specific training of staff, observation of client's condition and care, and assessment of client's satisfaction with services. At least one of the assigned personal care staff must be present at supervisory visits at least once every three months.

H. Investigation of complaints and critical incidents.

I. Counseling with staff on difficult cases, and potentially dangerous situations.

J. Communication with the case managers, the physician, and other providers on the care plan, as necessary to assure appropriate and effective care.

K. Oversight of record keeping by staff.

.44 A personal care agency may be denied or terminated from participation in Colorado Medicaid, according to procedures found at 10 CCR 2505-10 sections 8.050 through 8.051.44, based on good cause, as defined at 10 CCR 2505-10 section 8.051.01. Good cause for denial or termination of a personal care agency shall include, but not be limited to, the following:

A. Improper Billing Practices: Any personal care/homemaker agency that is found to have engaged in the following practices may be denied or terminated from participation in Colorado Medicaid:

1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home~~, as well as time of departure and time of arrival for all travel time billed~~. Providers shall submit or produce requested documentation in accordance with rules at 10 CCR 2505-10 section 8.079.62.

2. Billing for excessive hours that are not justified by the documentation of services provided, or by the client's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as such time as that authorized.

3. Billing for time spent by the personal care provider performing any tasks that are not allowed according to regulations in this 10 CCR 2505-10 section 8.489. This includes but is not limited to companionship, financial management, transporting of clients, skilled personal care, or delegated nursing tasks.

4. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.

b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 2 1/2 hours plus the number of hours billed for personal care and homemaker.

c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 1/2 hours.

d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related, to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

5. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 4 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

6. Billing for t~~T~~ravel t~~T~~ime is prohibited.

B. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services Without Also Receiving Payment For Home Health Services. A personal care/homemaker agency that is also certified as a Medicaid Home Health Agency may be terminated from Medicaid participation if the agency refuses to provide necessary and allowed HCBS personal care or homemaker services to clients who do not need Home Health services or who receive their Home Health services from a Home Health Agency not affiliated with the personal care/homemaker agency.

C. Prior Termination From Medicaid Participation. A personal care/homemaker agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a personal care/homemaker agency or any other type of service provider.

D. Abrupt Prior Closure. A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

.45 Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal agent.

.46 When a personal care agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.489.50 REIMBURSEMENT

.51 Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of one hour. The maximum unit rate shall be adjusted by the State as funding becomes available.

.52 Payment ~~may~~ does not include travel time to ~~and~~ or from the client's residence.~~, to be billed at the same unit rate as personal care services. The time billed for travel shall be listed separately from, but documented on the same form as, the time for service provision on each visit. Travel time must be summed over a period of at least a week and then rounded to the nearest hour for billing purposes. Travel time to one client's residence may not also be billed as travel time from another clients residence, as this would represent duplicate billing for the same time period.~~

.53 When personal care services are used to provide respite for unpaid primary care givers, the exact services rendered must be specified in the documentation.

.54 when an employee of a personal care agency provides services to a client who is a relative, the personal care agency shall bill under a special procedure code, in hourly units, using rates and hours which shall not exceed a total cost to Medicaid of more than $13.00 per day when averaged out over the number of days in the plan period.

.55 If a visit by a personal care staff includes some homemaker services, as defined at 10 CCR 2505-10 section 8.490., the entire visit shall be billed as personal care services. If the visit includes only homemaker services, and no personal care is provided, the entire visit shall be billed as homemaker services.

.56 If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.

.57 Effective 2/1/99, there shall be no reimbursement under this section for personal care services provided in uncertified congregate facilities. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving these services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued.

.58 Cost Reporting

A. All personal care agencies shall report and submit to the Department cost report information on a Department prescribed form.

B. By dates set forth by the Department, personal care providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or the State fiscal year.

C. Providers that do not comply with 10 CCR 2505-10 section 8.489.58 shall have their Medicaid provider agreement terminated.

8.490 HOMEMAKER SERVICES

8.490.1 DEFINITIONS

Homemaker Provider Agency means a provider agency that is certified by the state fiscal agent to provide Homemaker Services.

Homemaker Services means general household activities provided in the home of an eligible client provided by a Homemaker Provider Agency 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.

8.490.2 ELIGIBLE CLIENTS

8.490.2.A. Homemaker Services are available to clients in the Home and Community Based Services waivers for Elderly, Blind and Disabled and Persons with Mental Illness.

8.490.2.B. Homemaker Services are available to clients in the Home and Community Based Services waiver for Persons with Brain Injury when the client is also receiving personal care services.

8.490.3 BENEFITS

8.490.3.A. Covered benefits shall be for the benefit of the client and not for the benefit of other persons living in the home. Services shall be applied only to the permanent living space of the client.

8.490.3.B. Benefits include:

1. Routine light housecleaning, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas.

2. Meal preparation.

3. Dishwashing.

4. Bedmaking.

5. Laundry.

6. Shopping.

7. Teaching the skills listed above to clients who are capable of learning to do such tasks for themselves. Teaching shall result in a decrease of weekly units required within ninety days. <u>If such a savings in service units is not realized, teaching shall be deleted from the care plan.</u>

8.490.3.C. Benefits do not include:

1. Personal care services.

2. Services the person can perform independently.

3. Homemaker services provided by family members per 10 CCR 2505-10 section 8.485.200.F

8.490.3.D. Homemakers Services provided in uncertified congregate facilities are not a benefit.

8.490.4 HOMEMAKER PROVIDER AGENCY RESPONSIBILITIES

8.490.4.A. All providers shall be certified by the Department as a Homemaker Provider Agency.

8.490.4.B. The Homemaker Provider Agency shall conform to all general certification standards and procedures at 10 CCR 2505-10 section 8.487

8.490.4.C. The Homemaker Provider Agency shall assure and document that all staff receive at least eight hours of training or have passed a skills validation test prior to providing unsupervised homemaker services. Training or skills validation shall include:

1. The areas detailed in 10 CCR 2505-10 section 8.490.3.B.

2. Proper food handling and storage techniques.

3. Basic infection control techniques including universal precautions.

4. Informing staff of policies concerning emergency procedures.

8.490.4.D. All Homemaker Provider Agency staff shall be supervised by a person who, at a minimum, has received training or passed the skills validation test required of homemakers, as specified above. Supervision shall include, but not be limited to, the following activities:

1. Train staff on agency policies and procedures.

2. Arrange and document training.

3. Oversee scheduling and notify clients of schedule changes.

4. Conduct supervisory visits to client's homes at least every three months or more often as necessary for problem resolution, staff skills validation, observation of the home's condition and assessment of client's satisfaction with services.

5. Investigate complaints and critical incidents.

8.490.5 REIMBURSEMENT

8.490.5.A. Payment for Homemaker Services shall be the lower of the billed charges or the maximum rate of reimbursement set by the Department. Reimbursement shall be per unit of 15 minutes.

8.490.5.B. Payment ~~may~~ does not include travel time to ~~and~~ or from the client's residence.~~, to be billed at the same unit rate as Homemaker Services. The time billed for travel shall be listed separately from, but documented on the same form as the actual service provided. Travel time shall be totaled over a period of at least a week and rounded to the nearest 15 minutes for billing~~

~~purposes. Travel time to one client's residence shall not be billed as travel time from another client's residence.~~

8.490.5.C. If a visit by a home health aide from a home health agency includes Homemaker Services, only the home health aide visit shall be billed.

8.490.5.D. If a visit by a personal care provider from a personal care provider agency includes Homemaker Services, the Homemaker Services shall be billed separately from the personal care services.

8.490.5.E. Each visit shall be billed to the Medicaid fiscal agent with the following documentation to be retained at the provider agency

1. The nature and extent of services.

2. The provider's signature.

3. The date and time of arrival and departure from a client's home.

~~4. The date and time of arrival and departure time for travel.~~

8.516.10 INDEPENDENT LIVING SKILLS TRAINING

D. REIMBURSEMENT

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Technical Revisions to Case Management, Sections 8.300, 8.400, 8.500, 8.600 & 8.700
Rule Number: MSB 20-08-25-A
Division / Contact / Phone: Case Management and Quality Performance Division / Michelle Topkoff / 303-866-3659

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,20-08-25-A

3. This action is an adoption of: Amendments

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

   Sections(s) 8.300, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10), pages 32-61

   Sections(s) 8.400, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10), pages 1-250.

   Sections(s) 8.500, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10), pages 1-457.

   Sections(s) 8.600, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10)., pages 1-92

   Section(s) 8.761.14 , Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10), page 55.

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). YesYes

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.390 with the proposed text beginning at 8.390 through the end of 8.390.3. Replace the current text at 8.392 with the proposed text beginning at 8.392 through the end of 8.392.1.C. Replace the current text at 8.393 with the proposed text beginning at 8.393.1.A through the end of 8.393.6.B. Replace the current text at 8.400 with the proposed text beginning at 8.400 through the end of 8.405.42. Replace the current text at 8.408.76 through the end of 8.408.76. Replace the current text at 8.409.56 with the proposed text beginning at 8.409.56 through the end of 8.409.56. Replace the current text at 8.423 with the proposed text beginning at 8.423 through the end of 8.423.D. Replace the current text at 8.430.3 with the proposed text beginning at 8.430.3.A through the end of 8.430.3.A. Replace the current text at 8.443.2 with the proposed text beginning at 8.443.2 through the end of 8.443.20. Replace the current text at 8.449.1 with the proposed text beginning at 8.449.1 through the end of 8.499.2. Replace the text at 8.470 with the proposed text beginning at 8.470.1 through the end of 8.470.1. Replace the current text at 8.485.50 with the proposed text beginning at 8.485.50 through the end of 8.485.72. Replace the text at 8.485.90 with the proposed text beginning at 8.485.90 through the end of 8.485.98. Replace the current text at 8.486.20 with the proposed text beginning at 8.486.20 through the end of 8.486.41. Replace the current text at 8.486.80 with the proposed text beginning at 8.486.80 through the end of 8.486.81. Replace the current text at 8.486.100 with the proposed text beginning at 8.486.100 through the end of 8.486.102. Replace the current at 8.486.300 with the proposed text beginning at 8.486.300 through the end of 8.486.301. Replace the current text at 8.486.400 with the proposed text beginning at 8.486.400 through the end of 8.486.401. Replace the current text at 8.486.500 with the proposed text beginning at 8.486.500 through the end of 8.486.501. Replace the current text at 8.487 with the proposed text beginning at 8.487.10 through the end of 8.487.10. Replace the current text at 8.493.4 with the proposed text beginning at 8.493.4 through the end of 8.493.4.H. Replace the current text at 8.495 with the proposed text beginning at 8.495 through the end of 8.495.6.K. Replace the current text at 8.500 with the proposed text beginning at 8.500 through the end of 8.500.18.E. Replace the current text at 8.500.90 with the proposed text beginning at 8.500.90 through the end of 8.500.108.E. Replace the current text at 8.501 with the proposed text beginning at 8.501 through the end of 8.501.7. Replace the current text at 8.503 with the proposed text beginning at 8.503 through the end of 8.503.170. Replace the current text at 8.504 with the proposed text beginning at 8.504 through the end of 8.504.9. Replace the current text at 8.505 with the proposed text beginning at 8.505 through the end of 8.505.4. Replace the current text at 8.506 with the proposed text beginning at 8.506 through the end of 8.506.12.H. Replace the current text at 8.507 with the proposed text beginning at 8.507 through the end of 8.510.18.D. Replace the current text beginning at 8.515 with the proposed text beginning at 8.515.1 through the end of 8.515.85.O. Replace the current text at 8.516 with the proposed text beginning at 8.516.10 through the end of 8.516.10.C. Replace the current text

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

beginning at 8.516.30 with the proposed text beginning at 8.516.30 through the end of 8.517.11.C. Replace the current text at 8.519 with the proposed text beginning at 8.519 through the end of 8.519.18.D. Replace the current text at 8.520.5 with the proposed text beginning at 8.520.5.A through the end of 8.520.5.A. Replace the current text at 8.520.9.B with the proposed text beginning at 8.520.9.B through the end of 8.520.11.B. Replace the current text at 8.550 with the proposed text beginning at 8.550.1 through the end of 8.550.2.B. Replace the current text at 8.550.5 with the proposed text beginning at 8.550.5.A through the end of 8.550.6.B. Replace the current text at 8.550.8 with the proposed text beginning at 8.550.8.D through the end of 8.550.9.A. Delete the current text at 8.555 through the end of 8.555. Replace the current text at 8.600 with the proposed text beginning at 8.600.1 through the end of 8.600.6. Replace the current text at 8.607.2 with the proposed text beginning at 8.607.2 through the end of 8.607.6. Replace the current text at 8.607.8 with the proposed text beginning at 8.607.8 through the end of 8.807.8.B. Replace the current text at 8.608.6 with the proposed text beginning at 8.608.6 through the end of 8.608.6. Replace the current text at 8.608.8 with the proposed text beginning at 8.608.8 through the end of 8.608.D. Replace the current text at 8.612 with the proposed text beginning at 8.612.1 through the end of 8.612.1. Replace the current text at 8.613 with the proposed text beginning at 8.613.A through the end of 8.613.M. Replace the current text at 8.761 with the proposed text beginning at 8.761.14 through the end of 8.761.14.d. This rule is effective January 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Technical Revisions to Case Management, Sections 8.300, 8.400, 8.500, 8.600 & 8.700
Rule Number: MSB 20-08-25-A
Division / Contact / Phone: Case Management and Quality Performance Division / Michelle Topkoff / 303-866-3659

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).

   Technical changes have been made throughout 8.300, 8.400, 8.500, and 8.600 and 8.761.14. The revisions reflect corrections to grammar, punctuation, and spelling errors; inclusion of member choice and person-first language; and removal of outdated terminology, regulations and references.

   The amendments also reflect changes to rule that reflect changes in Single Entry Point contracts made during the most recent contract period.

   Recently several administrative requirements were suspended during the COVID-19 pandemic, to allow for necessary safety precautions, to reduce administrative burden and expediate access to services. Stakeholders requested the Department make some of these changes permanent. After consideration, the Department found no negative outcome for members and, therefore, submitted waiver amendments to their Federal partner, Centers for Medicare and Medicaid Services. Those waiver amendments remove the requirement to obtain a Professional Medical Information Page from the member's licensed practitioner on an annual basis, allow for phone/virtual monitoring visits with approval from the Department, and allow for digital signatures. Changes to the rules are required to align with the HCBS waiver amendments effective January 1, 2020.

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:

Initial Review	**10/09/20**	Final Adoption	**11/13/20**
Proposed Effective Date	**12/30/20**	Emergency Adoption	

DO NOT PUBLISH THIS PAGE

Section 24-4-103.3 C.R.S. (2014); Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020); 25.5-6-105 CRS (2020).

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Technical Revisions to Case Management, Sections 8.300, 8.400, 8.500, 8.600 & 8.700
Rule Number: MSB 20-08-25-A
Division / Contact / Phone: Case Management and Quality Performance Division / Michelle Topkoff / 303-866-3659

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.

   These rule changes will affect HCBS providers, case managers and members. They will also affect Department PASRR contract vendors, members' physicians and office staff, and HCBS case management agencies. All classes of persons affected will be benefited by the reduced paperwork. Members and case management agencies will benefit from additional flexibility to conduct in-person monitoring when needed. Members, providers and case management agencies will benefit from the efficiency of electronic signatures. Members will benefit from the inclusion of person-first language. All classes of persons will benefit from the removal of outdated terminology, regulations and references. There are no direct costs related to these proposed rule changes.

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

   A qualitative positive impact of the proposed rule changes due to increased person centered-language and updated language is expected. Quantitatively, time, effort and costs will be saved by being able to sign forms electronically and by not requiring every member to obtain a PMIP from their physician's automatically each year.

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

   There are no probable costs to the Department or other agencies to implement or enforce the proposed rule. There is no anticipated budgetary impact or state revenues. Any changes the revised rule cause to operational or procedural systems will serve to alleviate administrative burden and improve access to care and services.

   [Click **here** and type text]

4. 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 achieving the purpose of these proposed rule changes. There is no anticipated budgetary impact, nor cost associated with these technical changes.

5. 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 the extent to which the elimination of requirements for in-person monitoring visits could be eliminated and whether the PMIP could be eliminated completely, as well as other suggestions from stakeholders in reaction to temporary COVID-19 changes and decided that making any other changes permanent could not be done without jeopardizing the health, safety and welfare of the members and eligibility determination for waiver programs.

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

8.390.1 DEFINITIONS

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

B. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers), chosen by the individual, conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the ULTC 100.2 to complete assessments.

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

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

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

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

G. Failure to Satisfy the Scope of Work means acts or failures to actincorrect or improper activities or inactions by the Single Entry Point Aagency that constitute nonperformance or breach of the in terms of its contract with the Department.

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

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

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

K. Home and Community Based Services (HCBS) waivers means services and supports authorized through a waiver under Section 1915(c) of the Social Security Act and provided in home- and community-based settings to individuals who require an institutional level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).~~Home and Community Based Services (HCBS) Programs means the specific HCBS programs for which Single Entry Point agencies shall provide case management services, including Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI).~~

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

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

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

O. LTSS Program means any of the following: publicly funded program~~s including, but not limited to~~, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All-~~-~~Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-~~-~~Term Home Health (LTHH).

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

~~Q.Private Pay Individual means an individual for whom reimbursement for case management services is received from sources other than a Department-administered program, including the individual's own financial resources~~RQ. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to ~~verify the Client needs institutional Level of Care.~~certify level of care. ~~means the medical information signed by a licensed medical professional used as a component of the Assessment (ULTC-100.2) to determine the client's need for institutional care.~~

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

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

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

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

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

~~X. State- Designated Agency means a Single Entry Point agency designated to perform specified functions that would otherwise be performed by the county department(s) of social services.Y~~W. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. ~~Support planning~~Support Planning informs the individual seeking or receiving services of his or her rights and responsibilities.

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

8.390.2 LEGAL AUTHORITY

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

8.390.3 CHARACTERISTICS OF INDIVIDUALS RECEIVING SERVICES IN LTSS PROGRAMS

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

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

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

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

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

1. ~~Reimbursement for SEP functions shall be determined by the number of counties included in a district and by the number of individuals served, subject to the availability of funds in the Department's annual appropriation for each SEP Agency.~~

   a. ~~A SEP agency that serves a multi-county district shall annually receive a base amount for each county included in the district, plus an amount for each individual served, to be determined annually by the Department.~~

   b. ~~A SEP agency that serves a district composed of only one county shall not receive the base amount, but shall receive an amount for each individual served each year.~~

   c. ~~The amount for each individual shall be based on the number of individuals served in LTSS programs.~~

~~**8.392.1.B Cost Allocation**~~

~~1. The Department shall make monthly payments to each designated SEP agency using a methodology which shall be specified in the contract between the state and the agency.~~

~~2. Each fiscal year, the Department allocates funds for services provided by SEP agencies from the Department's appropriation. Payments to SEP agencies shall not exceed this allocation unless additional funds are appropriated by the General Assembly.~~

~~3. At the end of the contract year, actual individual and activity counts are reconciled against projected individual and activity counts. This process may result in either funds owed to the Department for payments made in excess of services delivered, or funds owed to SEP agencies for services delivered in excess of funds received. At the conclusion of the reconciliation process the Department issues reconciliation statements to collect for overpayments or adjusts for underpayments up to the aggregate amount allocated.~~

~~4. Allowable agency expenditures are those which the Department deems allowed or required, in accordance with the following federal rules: CFR Title 45, Part 74, Appendix C; Office of Management and Budget 2 CFR Part 200 Super Circular, January 2014; and U.S. Department of Health and Welfare, December 1976, Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government (OASC-10).~~

   ~~a. These federal regulations are subject to change, and any change in regulations shall be instructed by the Department.~~

~~5. SEP agencies may be audited by representatives of the Department, its designee and/or independent audit firms, in accordance with state and federal rules.~~

~~6. Payments are audited by the Department and may result in adjustments to reimbursement.~~

~~7. SEP agencies shall maintain documentation to support the actual costs of operation. Quarterly reports submitted to the Department shall document time expended by SEP Agency employees on specified programs, in accordance with a Department prescribed time analysis method.~~

~~8. For case management functions, the Department shall make monthly payments to each designated SEP agency using a methodology which shall be specified in the contract between the Department and the agency.~~

~~**8.392.1.C Private Pay Individuals**~~

~~SEP agencies may provide case management services to private pay individuals seeking or receiving services at the agency's discretion.~~

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.A Administration of a Single Entry Point

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

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

    b. The SEP ~~agency~~Agency shall have the capacity to accept ~~multiple~~ funding from multiple source~~s public dollars~~;

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

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

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

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

8.393.1.B. Community Advisory Committee

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

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

    b. The Community Advisory Committee shall provide public input and guidance to the SEP ~~agency~~Agency in the review of service delivery policies and procedures, marketing

strategies, resource development, overall SEP ~~agency~~Agency operations, service quality, individual satisfaction and other related professional problems or issues.

8.393.1.C. Personnel System

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

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

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

8.393.1.D. ~~Accounting System~~

~~1. The SEP agency shall follow Ggenerally Aaccepted Aaccounting Principlespractices (GAAP) and comply with all rules and regulations for accounting practices set forth by the State.~~

~~a. In addition, the SEP agency shall assure the following:~~

~~i. Funds are used solely for authorized purposes;~~

~~ii. All financial documents are filed in a systematic manner to facilitate audits;~~

~~iii. All prior years' expenditure documents are maintained for use in the budgeting process and for audits; and~~

~~iv. Records and source documents are made available to the Department, its representative, or an independent auditor for inspection, audit, or reproduction during normal business hours.~~

~~b. The SEP agency shall be audited annually and shall submit the final report of the audit to the Department within thirty (30) days of receipt of the final report.six (6) months after the end of the state's fiscal year. The SEP agency shall assure timely and appropriate resolution of audit findings and recommendations.~~

~~c. SEPs are subrecipients of federal funding and therefore are subject to federal subrecipient requirements. See the Office of Management and Budget Super Circular, 2 C.F.R. 200.330-32 (2013).~~

~~i. Subrecipient (the SEP agency) means a non-Federal entity that receives a Subaward from a Recipient (the Department) to carry out part of a Federal program, but does not include an individual that is a beneficiary of such program. A Subrecipient may also be a recipient of other Federal Awards directly from a Federal Awarding Agency.~~

~~8.393.1.E. Liability Insurance Coverage~~

~~The SEP agency shall maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements for contract agencies.~~

8.393.1.D~~E~~. Information Management

1. The SEP ~~agency~~Agency shall, in a format specified by the Department, be responsible for the collection and reporting of summary and individual-specific data including but not limited to information and referral services provided by the ~~agency~~Agency, program eligibility determination,

financial eligibility determination, Ssupport Pplanning, service authorization, critical incident reporting, monitoring of health and welfare, monitoring of services, resource development and fiscal accountability.

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

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

c. The SEP agency shall have adequate phone and IMSsc to manage the administrative requirements necessary to fulfill the responsibilities of the SEP.

8.393.1.EG. Recordkeeping

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

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

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

8.393.1.FH. Confidentiality of Information

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

8.393.1.GI. Individual Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

8.393.1.~~HJ~~. Access

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

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

b. The SEP ~~agency~~Agency shall comply with nondiscrimination requirements~~anti-discriminatory provisions~~, as defined by federal and Department rules and outlined in contract.

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

8.393.1.~~IK~~. Staffing Patterns

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

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

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

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

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

8.393.1.JL. Qualifications of Staff

1. The SEP agencyAgency's supervisor(s) and case manager(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

a. Case managers shall have at least a bachelor's degree in one of the human behavioral science fields (such as human services, nursing, social work, psychology, etc.).

b. An individual who does not meet the minimum educational requirement may qualify as a Single Entry Point agencyAgency case manager under the following conditions:

i. Experience as a caseworker or case manager with the LTSS population, in a private or public social services agencyAgency may substitute for the required education on a year for year basis.

ii. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

iii. The SEP AgencyAgency shall request a written waiver/memo from the Department in the event that the potential case manager does not meet minimum educational requirements. A copy of this waiver, if granted, shall/ memo stating Department approval will be kept in the case manager's personnel file that justifies the hiring of a case manager who does not meet the minimum educational requirements.

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

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

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

iii. Interviewing and assessment skills;

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

v. Ability to develop support planSupport Plans and service agreements;

vi. Knowledge of LTSS and other community resources; and

vii. Negotiation, intervention and interpersonal communication skills.

d. The ~~Single Entry Point~~SEP ~~agency~~Agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of LTSS.

8.393.1.M. Functions of the Case Manager~~.~~

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

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

b. The case manager shall have in-person monitoring at least one (1) time during the Support Plan year. The case manager shall ensure one required monitoring is conducted in-person with the Member, in the Member's place of residence.~~a face-to-face contact with the individual at least every six (6) months, or more frequently if warranted by the individual's condition or the rules of the LTSS Program in which the individual is enrolled, and shall update the ULTC 100.2 and Support Plan in the IMS to reflect any changes in condition or services~~. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

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

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

i. The quality of services and supports provided;

ii. The health and safety of the individual; and

iii. The utilization of services ~~with respect to the Support Plan and the Prior Authorization Request (PAR)~~.

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

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

ii. Overall level of functioning;

iii. Mental status or cognitive functioning;

iv. Duration of disabilities;

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

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

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

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

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

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

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

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

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

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

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

   f. Assumption of case management duties when necessary.

8.393.1.LO. Training of Single Entry Point Agency Staff

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

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

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

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

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

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

      v. Federal and state requirements for the SEP agencyAgency.

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

8.393.1.MP. Provision of Direct Services

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

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

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

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

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

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

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

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

8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

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

8.393.2.A. Protective Services

1. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of mistreatment, abuse, neglect, ~~or~~ exploitation or a harmful act, the

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

8.393.2.B. Intake, /Screening and /Referral

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

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

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

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

   ~~d~~c. A screening to determine whether ~~or not~~ a functional eligibility assessment is needed;

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

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

2. When LTSS are to be reimbursed through one or more of the ~~publicly-funded~~publicly funded LTSS programs served ~~administered~~ by the SEP system~~, the SEP staff shall~~:

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

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

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

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

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

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

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

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

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

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

8.393.2.C. Initial Assessment

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

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

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

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

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

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

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

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

2. Under no circumstances shall the start date for functional eligibility based on the See S~~s~~ection 8.486.30, ASSESSMENT~~, Under~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Coordinate the admission date with the facility;

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

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

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

8.393.2.D. Reassessment

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

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

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

~~a. Obtain diagnostic information through the Professional Medical Information Page (PMIP) form, from the individual's medical provider at least annually, or sooner if the individual's condition changes or is required by program criteria~~;

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

~~b~~c. Review ~~support plan~~Support Plan, service agreements and provider contracts or agreements;

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

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

~~f~~e. Annually, or more often if indicated, complete a new S~~s~~upport P~~p~~lan and service agreements;

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

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

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

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

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

~~5. The ULTC-100.2 shall be reviewed during each six- (6-) month contact and updated to reflectdue to any change in the individual's condition or status. If there is no change in the individual's condition or status, the case manager shall document in the Department-prescribed IMS that the ULTC-100.2 has been reviewed but not updated.~~

~~6~~5. In order to assure quality of services and supports and the health and welfare of the individual, the case manager shall ask for permission from the individual to observe the individual's residence as part of the reassessment process, but this shall not be compulsory of the individual. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.). ~~.~~

8.393.2.E. Support Plan

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

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

3. The SEP Aagency shall:

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

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

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

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

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

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

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

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

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

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

   k. Explain the appeals process to the individual.

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

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

   b. Is led by the individual, the individual's parent's (if the individual is a minor), ~~family members~~ and/or the individual's authorized representative ~~with the case manager~~;

   c. Includes people chosen by the individual;

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

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

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

5. Prudent purchase of services:

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

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

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

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

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

8.393.2.F. Cost Containment

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

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

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

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

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

8.393.2.G. On~~-G~~going Case Management

1. The functions of the on~~-~~going case manager shall be:

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

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

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

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

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

2. Include activities to ensure:

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

B. Services in the S~~s~~upport P~~p~~lan are adequate; and

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

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

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

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

~~3. The SEP Agency must also observe the individual's residence with the individual present to establish~~ that ~~the residence is a safe environment at least annually~~.

~~a. If the case manager does not observe the individual's residence at the annual face-to-face reassessment, the case manager to shall align the annual visit to the individual's residence with a six- (6-) month face-to-face contact~~. ~~Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)~~

b3. If the case manager makes an observation in the individual's residence that is inconsistent with the ULTC 100.2 and/or Support Plan, the case manager shall update the assessment and/or Support Plan to reflect the observation. The case manager may require the Contractor to revise the Support Plan and Prior Authorization if the results of the monitoring indicate that the plan is inappropriate, the services as described in the plan are untimely, or the amount of services need to be changed to meet the Client's needs.

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

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

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

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

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

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

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

   g. Referral to community resources as needed.

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

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

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

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

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

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

    a. Critical Incident reporting is required when the following occurs: Each This report must include:

       i. a. Individual's name;

b. Individual's identification number;

~~c. HCBS Program;~~
~~d. Incident type;~~Injury/Illness;

ii. Missing Person;

iii. Criminal Activity;

iv. Unsafe Housing/Displacement;

v. Death;

vi. Medication Management Issues;

vii. Other High-Risk Issues;

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

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

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

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

d. Each Critical Incident Report must include:

i. incident type

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

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

~~e~~ii. Date and time of incident;

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

iv.~~g.~~ Individuals involved; ~~and~~

v~~h~~. Description of ~~R~~incident, and~~resolution.~~

vi. Resolution of incident, if applicable.

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

8.393.2.H. Case Recording/Documentation

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

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

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

   b. All State-required forms; and

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

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

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

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

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

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

   e. The person making each entry must be identified;

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

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

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

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

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

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

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

8.393.2.I. Resource Development Committee

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

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

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

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

    a. The resource development plan shall include:

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

        ii. Gaps in LTSS resources within the SEP district;

        iii. Strategies for developing needed resources; and

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

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

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

8.393.3 DENIALS/DISCONTINUATIONS/ADVERSE ACTIONS

8.393.3.A. Denial Reasons and Notification Actions

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

    a. Financial Eligibility

        i. The eligibility enrollment specialist from the county department of social services shall notify the individual of denial or discontinuation for reasons of financial eligibility~~,~~ and shall inform the individual of appeal rights in accordance with Section 8.057. ~~The case manager shall not attend the appeal hearing for a denial~~

~~or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the Department.~~

~~1)~~ii If the individual is found to be financially ineligible for LTSS programs, the SEP A~~a~~gency shall notify the individual~~s~~ of the adverse action and inform the individual of their appeal rights in accordance with Section 8.057. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the Department.

b. Functional Eligibility and Target Group

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

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

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

c. Receipt of Services

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

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

2) The individual has two (2) times in a thirty~~-~~ ~~(30-)~~ day consecutive period~~,~~ refused to schedule an appointment for assessment~~, six- (6-) month visit~~, or monitoring required by these regulations;~~, or~~

3) The individual ~~or individuals representative refuses to sign the Intake form, Support Plan form, Release of Information form, or other forms as required to receive services or if the SEP agency does not receive the completed Professional Medical Information Page (PMIP) form.~~ has failed to keep three ~~(3)~~ scheduled assessment appointments within a thirty~~-~~ ~~(30-)~~ day consecutive ~~day~~ period; or

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

d. Institutional Status

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

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

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

e. Cost-Effectiveness/Service Limitations

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

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

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

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

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

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

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

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

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

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

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

8.393.3.C. Notification

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

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

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

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

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

8.393.4. COMMUNICATION

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

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

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

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

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

8.393.5 FUNCTIONAL ELIGIBILITY DETERMINATION

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

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

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

3. If the assessment indicates approval, the SEP A~~a~~gency shall notify the appropriate parties ~~in accordance with Section 8.393.3.A.2 and 8.383.4.4.~~.

4. If the assessment indicates denial, the SEP A~~a~~gency shall notify the appropriate parties in accordance with 8.393.3.A.2. ~~and 8.383.4.~~

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

8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

8.393.6.A. Intercounty Transfers

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

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

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

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

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

      i. ULTC 100.2, certified by the SEP;

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

      iii. Verification of Medicaid eligibility status.

8.393.6.B. Inter-district Transfers

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

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

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

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

   d. If the individual is moving from one SEP D~~d~~istrict to another SEP D~~d~~istrict to enter an ~~Alternative Care Facility (~~ACF~~)~~, the transferring SEP A~~a~~gency shall forward copies of the individual's records to the ~~Alternative Care Facility (~~ACF~~),~~ prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

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

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

g. The receiving SEP Aagency shall review the Ssupport Pplan and the ULTC 100.2 and change or coordinate services and providers as necessary.

h. If indicated by changes in the Ssupport Pplan, the receiving SEP Aagency shall revise the Ssupport Pplan and prior authorization forms as required by the publicly funded program.

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

8.400 ~~LONG TERM~~LONG-TERM CARE

.10 ~~Long term~~Long-term care includes nursing facility care as part of the standard Medicaid benefit package, and Home and Community Based Services provided under waivers granted by the Federal government.

.101 Nursing facility services and Home and Community Based Services are benefits only under Medicaid. Nursing Facility Services and Home and Community Based Services are non-benefits under the Modified Medical Program.

.102 State only funding will pay for nursing facility services for October 1988 and November 1988 for clients under the Modified Medical Program who were residing in a nursing facility October 1, 1988. This is intended to give clients time to qualify for Medicaid.

.103 Until the implementation of SB 03-176 a legal immigrant, as defined in C.R.S. section 25.5-4-103, who received Medicaid services in a nursing facility or through Home and Community Based Services for the Elderly, Blind and Disabled on July 1, 1997, who would have lost Medicaid eligibility due to his/her immigrant status, shall continue to receive services under State funding as long as he/she continues to meet Medicaid eligibility requirements.

.104 If a nursing facility client, who is only eligible for the Modified Medical Program, is making a valid effort to dispose of excess resources but legal constraints do not allow the conversion to happen by December 1, 1988, the client may have 60 additional days to meet SSI eligibility requirements.

.11 Standard Medicaid ~~long term~~long-term care services are services provided in:

- Skilled care facilities (SNF)

- Intermediate care facilities (ICF)

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

.12 Home and Community Based Services under the Medicaid Waivers include distinct service programs designed as alternatives to standard Medicaid nursing facility or hospital services for discrete categories of clients. These waivers are Home and Community Based Services Waiver for Persons Who Are Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based Services Waiver for Persons with Spinal Cord Injury (HCBS-SCI), Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community Based Services Waiver for Persons With Brain Injury (HCBS-BI); Home and Community Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD), Supportive Living Services Waiver (HCBS-SLS); Home and Community Based Services Waiver for Children with Autism (HCBS-CWA), Children with Life-limiting Illness Waiver (HCBS-CLLI), Children's Habilitation Residential Program Waiver (HCBS-CHRP), Children Extensive Supports Waiver (HCBS-CES), Children's Home and Community Based Services Waiver (HCBS-CHCBS) and Home and Community Based Services for those inappropriately residing in nursing facilities (OBRA '87).

.13 Unless specified by reference to the specific programs described above, the term Home and Community Based Services where it appears in these rules and regulations shall refer to the programs described herein above, and the rules and regulations within this section shall be applicable to all Home and Community Based Services programs.

.14 Nursing facilities are prohibited from admitting any new client who has mental illness or intellectual or developmental disability, as defined in ~~10 CCR 2505-10 section~~Section 8.401.18 Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability unless that client has been determined to require the level of services provided by a nursing facility as defined in ~~10 CCR 2505-10 S~~section 8.401.19.

.15 Clients eligible for Home and Community Based Services are eligible for all Medicaid services including home health services.

.16 Target Population Definitions. For purposes of determining appropriate type of ~~long term~~long-term services, including home and community~~-~~-based services, as well as providing for a means of properly referring clients to the appropriate community agency, the following target group designations are established:

A. Developmentally Disabled - includes all clients whose need for ~~long term~~long-term care services is based on a diagnosis of Developmental Disability and Related Conditions, as defined in ~~10 CCR 2505-10 section~~Section 8.401.18.

B. Mentally Ill - includes all clients whose need for ~~long term~~long-term care is based on a diagnosis of mental disease as defined in ~~10 CCR 2505-10 section~~Section 8.401.18.

C. Functionally Impaired Elderly - includes all clients who meet the level of care screening guidelines for SNF or ICF care, and who are age 65 or over. Clients who are mentally ill, as defined in ~~10 CCR 2505-10 section~~Section 8.401.18, shall not be included in the target group of Functionally Impaired Elderly, unless the person's need for ~~long term~~long-term care services is primarily due to physical impairments that are not caused by any diagnosis included in the definition of mental illness at ~~10 CCR 2505-10 S~~section 8.401.18, and determined by ~~Utilization Review Contractor~~ (URC) from the medical evidence.

D. Physically Disabled or Blind Adult - includes all clients who meet the level of care screening guidelines for SNF or ICF care, and who are age 18 through 64. Clients who are developmentally disabled or mentally ill, as defined in ~~10 CCR 2505-10 S~~section 8.401.18, shall not be included in the Physically Disabled or Blind target group, unless the person's need for ~~long term~~long-term care services is primarily due to physical impairments not caused by any diagnosis included in the definition of intellectual or developmental disability or mental illness at ~~10 CCR 2505-10 section~~Section 8.401.18, as determined by ~~Utilization Review Contractor~~URC from the medical evidence.

E. Persons Living with AIDS - includes all clients of any age who meet either the nursing home level of care or acute level of care screening guidelines for nursing facilities or hospitals~~,~~ and have the -diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may alternatively request to be designated as any other target group for which they meet the definitions above.

.17 Services in Home and Community Based Services programs established in accordance with federal waivers shall be provided to clients in accordance with the ~~Utilization Review Contractor~~URC determined target populations as defined herein above.

8.401 LEVEL OF CARE SCREENING GUIDELINES

.01 The client must have been found by the URC ~~Utilization Review Contractor~~ to meet the applicable level of care guidelines for the type of services to be provided.

.02 The ~~Utilization Review Contractor~~URC shall not make a level of care determination unless the recipient has been determined to be Medicaid eligible or an application for Medicaid services has been filed with the County Department of Social/Human services.

.03 Payment for skilled (SNF) and intermediate nursing home care (ICF) Payment for skilled (SNF) and intermediate nursing home care (ICF)~~ and Home and Community Based Services~~ will only be made for clients whose functional assessment and frequency of need for skilled and maintenance services meet the level of care guidelines for ~~long term~~long-term care.

.04 Payment for care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) will only be made for developmentally disabled clients whose programmatic and/or health care needs meet the level of care guidelines for the appropriate class of ICF/IIDs. ~~Payment for Home and Community Based Services for the Developmentally Disabled will only be made for developmentally disabled clients who meet the level of care guidelines for long term care services for the developmentally disabled.~~

.05 Services provided by nursing facilities are available to those clients that meet the guidelines below and are not identified as mentally ill or individuals with an intellectual or developmental disability by the Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability in ~~10 CCR 2505-10 10 CCR 2505-10 section~~Section 8.401.18.

8.401.1 GUIDELINES FOR LONG TERM CARE SERVICES (CLASS I SNF AND ICF FACILITIES, *HCBS-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP*, and ~~Long Term~~Long-term Home Health)

.11 The guidelines for ~~long term~~long-term care are based on a functional needs assessment in which individuals are evaluated in at least the following areas of activities of daily living:

- Mobility

- Bathing
- Dressing
- Eating
- Toileting
- Transferring
- Need for supervision

A. The functional needs of an individual ages 18 and under shall be assessed in accordance with Appendix A, the Age Appropriate Guidelines for the Use of ULTC 100.2 on Children.

.12 Skilled services shall be defined as those services which can only be provided by a skilled person such as a nurse or licensed therapist or by a person who has been extensively trained to perform that service.

.13 Maintenance services shall be defined as those services which may be performed by a person who has been trained to perform that specific task, e.g., a family member, a nurses' aide, a therapy aide, visiting homemaker, etc.

.14 Skilled and maintenance services are performed in the following areas:

- Skin care
- Medication
- Nutrition
- Activities of daily living
- Therapies
- Elimination
- Observation and monitoring

.15

A. The ~~Utilization Review Contractor~~URC shall certify as to the functional need for the nursing facility level of care. A ~~Utilization Review Contractor~~URC reviews the information submitted on the ULTC 100.2 and assigns a score to each of the functional areas described in 10 CCR 2505-10 ~~section~~Section 8.401.11. The scores in each of the functional areas are based on a set of criteria and weights approved by the State which measures the degree of impairment in each of the functional areas. When the score in a minimum of two ADLs or the score for one category of supervision is at least a (2), the ~~Utilization Review Contractor~~URC may certify that the person being reviewed is eligible for nursing facility level of care.

B. The ~~Utilization Review Contractor~~URC's review shall include the information provided by the functional assessment screen.

C. A person's need for basic Medicaid benefits is not a proper consideration in determining whether a person needs ~~long term~~long-term care services (including Home and Community Based Services).

D. The ULTC 100.2 shall be the comprehensive and uniform client assessment process for all individuals in need of ~~long term~~long-term care, the purpose of which is to determine the appropriate services and levels of care necessary to meet clients' needs, to analyze alternative forms of care and the payment sources for such care, and to assist in the selection of ~~long term~~long-term care programs and services that meet clients' needs most cost-efficiently.

LONG-TERM CARE ELIGIBILITY ASSESSMENT

General Instructions: To qualify for Medicaid long-term care services, the recipient/applicant must have deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision.

8.401.20 LEVEL II PASRR EVALUATION

.201 The purpose of the Level II evaluation is to determine whether:

A. Each individual with mental illness or intellectual or developmental disability requires the level of services provided by a nursing facility.

B. An individual has a major mental illness or is individuals with an intellectual or developmental disability.

C. The individual requires a Specialized Services program for the mental illness or intellectual or developmental disability.

.202 Basic Requirements for LEVEL II PASRR Evaluations and Determinations include:

A. The State Mental Health authority shall make determinations of whether individuals with mental illness require specialized services that can be provided in a nursing facility as follows:

1. The determination must be based on an independent physical and mental evaluation.

2. The evaluation must be performed by an individual or entity other than the State Mental Health authority.

B. The State Intellectual or developmental disability authority shall conduct both the evaluation and the determination functions of whether individuals with intellectual or developmental disability require specialized services that can be provided in nursing facilities.

C. The PASRR Level II contractor shall complete the evaluation within 10 working days of the referral from the ~~Utilization Review Contractor~~URC.

D. PASRR determinations made by the State Mental Health or Intellectual or developmental disability authorities cannot be countermanded by the Department through the claims payment process or through other utilization control/review processes, or by CDPHE, survey and certification agency, or by any receiving facility or other involved entities.

E. The Final Agency action by the Department may overturn a PASRR adverse determination made by State Mental Health or Intellectual or developmental disability authorities.

F. Timely filing of PASRR billings from providers is 120 days.

.203 An individual meets the requirements of a Depression Diversion Screen.

A. A Depression Diversion Screen shall be applied under the following conditions:

1. Depression is the only Level I positive finding (i.e. a depression diagnosis is the only Yes checked on the Level I screen); and

2. The ~~Utilization Review Contractor~~URC or the PASRR Level II Contractor for that geographic area shall make the determination of need for a Depression Diversion Screen.

B. The nursing facilities are not authorized to apply the Depression Diversion Screen.

C. When a non-major mental illness depression is validated as the only Level I positive finding through the Depression Diversion Screen, a complete Level II referral and evaluation is not required unless the individual's condition changes.

.204 Appeals Hearing Process for the PASRR Program

A. A resident has appeal rights when he or she has been adversely affected by a PASRR determination as a result of the Level II evaluation made by the State Mental Health or Intellectual or developmental disability authorities either at Pre- admission Screening or at Annual Resident Review.

B. Adverse determinations related to PASRR mean a determination made in accordance with ~~section~~Sections 1919(b)(3)(F) or 1919(e)(7)(B) of the Social Security Act that:

1. The individual does not require the level of services provided by a Nursing Facility; and/or

2. The individual does or does not require Specialized Services for mental illness or intellectual or developmental disability.

3. Section 1919 of the Social Security Act (1935) (42 U.S.C. section 1396r) is hereby incorporated by reference. The incorporation of 42 U.S.C. section 1396r excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

C. Appeals of Level of Care determination are processed through the Appeals ~~section~~Section related to the ~~Utilization Review Contractor~~URC's Level of Care process in ~~10 CCR 2505-10 s~~Section 8.057.

D. For adverse actions related to the need for Specialized Services, the individual or resident affected by the mental illness or ~~mental retardation~~intellectual or developmental disability determination may appeal through procedures established for appeals in the Recipient Appeals and Hearings ~~section of 10 CCR 2505-10 section~~ at Section 8.057.

.205 The Level II PASRR Evaluation Process

A. The ~~Utilization Review Contractor~~URC shall refer all Medicaid clients and private pay individuals who require a Level II evaluation, to the PASRR Level II contractor.

1. The PASRR Level II contractor shall complete the Level II evaluation~~.~~.

2. The State Medicaid program shall pay for the private pay evaluations.

3. Nursing facilities shall not complete the Level II evaluation.

4. The findings of these evaluations shall be returned to the ~~Utilization Review Contractor~~URC for review and referral to the State Mental Health and/or Intellectual or developmental disability authorities for final review and determination.

B. Evaluations shall be adapted to the cultural background, language, ethnic origin and means of communication used by the individual.

C. The Level II Mental Illness Evaluation for Specialized Services shall consist of the following:

1. A comprehensive medical examination of the individual. The examination shall address the following areas:

a. A comprehensive medical history;

b. An examination of all body systems; and

c. An examination of the neurological system which consists of an evaluation in the following areas:

1) Motor functioning;

2) Sensory functioning;

3) Gait and deep tendon reflexes;

4) Cranial nerves; and

5) Abnormal reflexes.

d. In cases of abnormal findings, additional evaluations shall be conducted by appropriate specialists; and

e. If the history and physical examinations are not performed by a physician, then a physician must review and concur with the conclusions and sign the examination form.

2. A psychosocial evaluation of the individual, which at a minimum, includes an evaluation of the following:

a. Current living arrangements;

b. Medical and support systems; and

c. The individual's total need for services are such that:

1) The level of support can be provided in an alternative community setting; or

2) The level of support is such that nursing facility placement is required.

3. A Functional Assessment shall be completed on the individual's ability to engage in activities of daily living.

4. A comprehensive psychiatric evaluation, at a minimum, must address the following areas:

a. A comprehensive drug history is obtained on all current or immediate past utilization of medications that could mask symptoms or use of medications that could mimic mental illness;

b. A psychiatric history is obtained;

c. An evaluation is completed of intellectual functioning, memory functioning, and orientation;

d. A description is obtained on current attitudes, overt behaviors, affect, suicidal or homicidal ideation, paranoia and degree of reality testing (presence and content of delusions, paranoia and hallucinations); and

e. Certification status under provisions at C.R.S. section 27-65-107 et.seq. and need for in-patient emergency psychiatric care shall be assessed. If an individual qualifies under the emergency provisions in the statute, emergency proceedings shall be considered. This action shall supersede any PASRR activity.

5. If the psychiatric evaluation is performed by a professional other than a psychiatrist, then a psychiatrist's countersignature shall be required.

6. The Mental Health evaluation shall identify all medical and psychiatric diagnoses which require treatment, and should include copies of previous discharge summaries from the hospital or nursing facility charts (during the past two years).

7. The Mental Health determination process shall insure that a qualified mental health professional, as designated by the State, must validate the diagnosis of mental illness and determine the appropriate level of mental health services needed.

D. The Level II Intellectual or developmental disability or related conditions evaluation for Specialized Services shall consist of the following:

1. A comprehensive medical examination review so that the following information can be identified:

a. A list of the individual's medical problems;

b. The level of impact on the individual's independent functioning;

c. A list of all current medications; and

d. Current responses to any prescribed medications in the following drug groups:

1) Hypnotics,

2) Anti-psychotics (neuroleptics),

3) Mood stabilizers and anti-depressants,

4) Antianxiety-sedative agents, and

5) Anti-Parkinsonian agents.

2. The Intellectual or developmental disability process must assess:

a. Self-monitoring of health status;

b. Self-administering and/or scheduling of medical treatments;

c. Self-monitoring of nutrition status;

d. Self-help development such as: toileting, dressing, grooming, and eating);

e. Sensorimotor development such as: ambulation, positioning, transfer skills, gross motor dexterity, visual motor/perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices improve the individual's functional capacity);

f. Speech and language (communication) development, such as: expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which non-oral communication systems improve the individual's functional capacity, auditory functioning, and extent to which amplification devices (e.g., hearing aid) or a program of amplification improve the individual's functional capacity);

g. Social development, such as: interpersonal skills, recreation-leisure skills, and relationships with others;

h. Academic/educational development, including functional learning skills;

i. Independent living development such as: meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bed making, care of clothing, and orientation skills (for individuals with visual impairments); and

j. Vocational development, including present vocational skills;

k. Affective development (such as: interests, and skills involved with expressing emotions, making judgments, and making independent decisions); and

l. Presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation (including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors).

3. The Level II Intellectual or developmental disability evaluation shall insure that a psychologist, who meets the qualifications of a qualified intellectual or developmental disability professional completes the following:

a. The individual's intellectual functioning measurement shall be identified; and

b. The individual's intellectual or developmental disability or related condition shall be validated.

4. The Level II Intellectual or developmental disability evaluation shall identify to what extent the individual's status compares with each of the following characteristics, commonly associated with need for specialized services including:

a. The inability to:

1) Take care of most personal care needs;

2) Understand simple commands;

3) Communicate basic needs and wants;

4) Be employed at a productive wage level without systematic ~~long term~~long-term supervision or support;

5) Learn new skills without aggressive and consistent training;

6) Apply skills learned to a training situation to other environments or settings without aggressive and consistent training; or

7) Demonstrate behavior appropriate to the time, situation or place, without direct supervision.

b. Demonstration of severe maladaptive behavior(s) which place the individual or others in jeopardy to health and safety;

c. Inability or extreme difficulty in making decisions requiring informed consent; and

d. Presence of other skill deficits or specialized training needs which necessitate the availability of trained intellectual or developmental disability personnel, 24 hours per day, to teach the individual functional skills.

5. The Intellectual or developmental disability evaluation shall collect information to determine whether the individual's total needs for services are such that:

a. The level of support may be provided in an alternative community setting; or

b. The level of support is such that nursing facility placement is required.

6. The Intellectual or developmental disability evaluation shall determine whether the individuals with an intellectual or developmental disability individual needs a continuous Specialized Services program.

.206 PASRR Findings from Level II Evaluations

A. PASRR Level II findings shall include the following documentation:

1. The individual's current functional level must be addressed;

2. The presence of diagnosis, numerical test scores, quotients, developmental levels, etc. shall be descriptive; and

3. The findings shall be made available to the family or designated representatives of the nursing facility resident, the parent of the minor individual or the legal guardian of the individual.

B. PASRR Findings from the Level II Evaluations shall be used by the ~~Utilization Review Contractor~~URC in making determinations whether an individual with mental illness or intellectual or developmental disability is appropriate or inappropriate for nursing facility care, and

C. The individual shall be referred back to the ~~Utilization Review Contractor~~URC for a determination of the need for ~~long term~~long-term care services if at any time it is found that the individual is not mentally ill or individuals with an intellectual or developmental disability, or has a primary diagnosis of dementia or Alzheimer's disease or related disorders or a non-primary diagnosis of dementia (including Alzheimer's disease or a related disorder) without a primary diagnosis of serious mental illness, or intellectual or developmental disability or a related condition.

D. The results of the PASRR evaluation shall be described in a report by the State Mental Health or Intellectual or developmental disability authorities, which includes:

1. The name and professional title of the person completing the evaluation, and the date on which each portion of the evaluation was administered.

2. A summary of the medical and social history including the individual's positive traits or developmental strengths and weaknesses or developmental needs.

3. The mental health services and/or intellectual or developmental disability services required to meet the individual's identified needs;

4. If specialized services are not recommended, any specific services identified which are of a lesser intensity than specialized services required to meet the evaluated individual's needs;

5. If specialized services are recommended, the specific services identified required to meet each one of the individual's needs; and

6. The basis for the report's conclusions.

E. Copies of the evaluation report will be made available to:

1. The individual and his or her legal representative;

2. The appropriate state authorities who make the determination;

3. The admitting or retaining nursing facility;

4. The individual's attending physician; and

5. The discharge hospital, if applicable.

.207 PASRR Determinations from the Level II Evaluation

A. Determinations which may result in admissions and/or specialized services shall include:

1. If an individual meets the level of care and needs the level of services provided in a nursing facility, as determined by the ~~Utilization Review Contractor~~URC, and is determined not mentally ill or individuals with an intellectual or developmental disability, the individual may be admitted to the facility.

2. If an individual does not meet the level of care (as determined by the ~~Utilization Review Contractor~~URC), and is determined to not be mentally ill or individuals with an intellectual or developmental disability through the PASRR determination and is not seeking Medicaid reimbursement, the individual may be admitted to the facility.

3. If the determination is that a resident or applicant for admission to a nursing facility requires BOTH the nursing facility level of care and specialized mental health or intellectual or developmental disability services, as determined by the ~~Utilization Review Contractor~~URC and the State Mental Health and Intellectual or developmental disability authorities:

   a. The individual may be admitted or retained by the nursing facility; and

   b. The State Mental Health or Intellectual or developmental disability authorities shall provide or arrange for the provision of specialized services needed by the individual while he or she resides in the nursing facility.

4. Nursing facilities admitting residents requiring specialized mental health or intellectual or developmental disability services shall be responsible for assuring the provisions of services to meet all the resident needs identified in the Level II evaluations. The provisions of services shall be monitored through the State's survey and certification process.

B. Determinations which may result in denial of admission include:

1. If an individual does not require nursing facility services and is seeking Medicaid reimbursement, the individual cannot be admitted to the nursing facility.

2. If the determination is that an individual requires neither the level of services provided in a nursing facility nor specialized services, the nursing facility shall:

   a. Arrange for the safe and orderly discharge of the resident from the facility; and

   b. Prepare and orient the resident for the discharge.

   c. Provide the resident with a written notice of the action to be taken and his or her grievance and appeal rights under the procedure found at ~~section~~ C.R.S. section 25-1-120 entitled “Nursing facilities - rights of patients”.

C. If the determination is that a resident does not require nursing facility services but requires specialized services, the following action shall be taken:

1. For ~~long term~~long-term residents who have resided continuously in a nursing facility at least 30 months before the date of the first annual review determination

and who require only specialized services, the nursing facility, in cooperation with the resident's family or legal representative and care givers, shall complete the following:

a. The resident shall be offered the choice of remaining in the facility or receiving services in an alternative appropriate setting; and

b. The resident shall be informed of institutional and non-institutional alternatives; and

c. The effect on eligibility for Medicaid services shall be clarified if the resident chooses to leave the facility, including the effect on readmission to the facility; and

d. The provision of specialized services shall be provided for~~,~~ or arranged regardless of the resident's choice of living arrangements.

2. For short term residents who require only specialized services and who have not resided in a nursing facility for 30 continuous months before the date of PASRR determination, the nursing facility, in conjunction with the State Mental Health or Intellectual or developmental disability authority, in cooperation with the resident's family or legal representative and caregivers, shall complete the following:

a. The safe and orderly discharge of the resident from the facility shall be arranged;

b. The resident shall be prepared and oriented for the discharge; and

c. A written notice shall be given to the resident notifying him or her of the action to be taken and of his or her grievance and appeal rights.

d. The provision of specialized services shall be provided or arranged, regardless of the resident's choice of living arrangements.

D. Any individual with mental illness, determined through the PASRR process, to be in need of in-patient psychiatric hospitalization, shall not be admitted to the nursing facility until treatment has been received and the individual certified as no longer needing in-patient psychiatric hospitalization.

8.401.21 SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

.211 Specialized Services shall include the following requirements:

A. Community Mental Health Centers and Community Centered Boards shall be authorized by the State to provide specialized services to individuals in Medicaid nursing facilities.

B. These services shall be reimbursed by the Medicaid program to the community mental health centers or community centered boards through ~~Department of Institutions~~The Department of Health Care Policy and Financing. The cost of these services shall not be reported on the Nursing Facility cost report.

C. Specialized services may be provided by agencies other than community mental health centers or community centered boards or other designated agencies on a fee for service

basis, but the cost of these services shall not be included in the Medicaid cost report or the Medicaid rate paid to the nursing facility.

.212 Specialized Services for Individuals with Mental Illness shall be defined as services, specified by the State, which include:

A. Specified services combined with the services provided by the nursing facility, resulting in a program designed for the specific needs of eligible individuals who require the services.

B. An aggressive, consistent implementation of an individualized plan of care.

.213 Specialized services shall have the following characteristics:

A. The specialized services and treatment plan must be developed and supervised by an interdisciplinary team which includes a physician, a qualified mental health professional and other professionals, as appropriate.

B. Specific therapies, treatments and mental health interventions and activities, health services and other related services shall be prescribed for the treatment of individuals with mental illness who are experiencing an episode of severe mental illness which necessitates supervision by trained mental health personnel.

.214 The intent of these specialized services is to:

A. Reduce the applicant or resident's behavioral symptoms that would otherwise necessitate institutionalization.

B. Improve the individual's level of independent functioning.

C. Achieve a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

.215 Levels of Mental Health services shall be provided, as defined by the State, including Enhanced and General Mental Health services.

.216 Specialized Services for Individuals with Intellectual or developmental disability shall be defined as a continuous program for each individual which includes the following:

A. An aggressive, consistent implementation of a program of specialized and generic training, specific therapies or treatments, activities, health services and related services, as identified in the plan of care.

B. The individual program plan includes the following:

1. The acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and

2. The prevention or deceleration of regression or loss of current optimal functional status.

8.402 ADMISSION PROCEDURES FOR ~~LONG TERM~~LONG-TERM CARE

8.402.01 PRE-ADMISSION REVIEW ~~(NOT FOR DEVELOPMENTAL DISABILITIES)~~

When a physician or designee wishes to obtain skilled or maintenance services for a client, he/she shall contact the regional ~~Utilization Review Contractor~~URC ~~(URC)~~. The ~~Utilization Review Contractor~~URC will request and record information about the client's condition and the proposed treatment plan.

In order to promote the most appropriate placement of ~~developmentally disabled clients~~ individuals with intellectual or developmental disabilities when skilled or maintenance services are sought, the physician shall, unless an emergency admission is required, refer the client to the ~~Residential Referral and Placement Committee (RR/PC) for the area served by the~~ Community Centered Board (CCB) where the client resides. Class I services shall be authorized by the ~~Utilization Review Contractor~~URC only when the following requirements have been met:

a. The ~~RR/PC~~ CCB determines, in collaboration with the physician and the client or the client's designated representative, that Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services or services available through Home and Community Based Services for ~~the Developmentally Disabled~~individuals with Developmental Disabilities (HCBS-DD) are not appropriate to meet the health care needs of the client.

b. ICF/IID or HCBS-DD services are not available if such services are appropriate.

c. The physician and the client or the client's designated representative choose~~s~~ Class I services in preference to services available specifically for individuals with intellectual or developmental~~ly disabled~~disabilities ~~clients~~, and the client meets the level of care criteria for these services.

Referrals by physicians of ~~developmentally disabled~~ individuals with intellectual or developmental disabilities ~~clients~~ for Class I services without review by the ~~RR/PC~~CCB will not be certified by the ~~Utilization Review Contractor~~URC for Medicaid reimbursement. Clients for whom ICF/IID or HCBS-DD services are appropriate as defined in ~~10 CCR 2505-10 section~~Section 8.401.18, subject to the physician's and the client's or the client's designated representative concurrence, shall be referred immediately to the ~~Utilization Review Contractor~~URC and to the appropriate Community Centered Board under the provisions at ~~10 CCR 2505-10 section~~Section 8.405.

.02 After reviewing the information taken from the physician or his designee, the ~~Utilization Review Contractor~~URC shall assign a target group designation based upon the primary reason for which ~~long term~~long-term care services are needed. The ~~Utilization Review Contractor~~URC shall follow the target group designations established at ~~10 CCR 2505-10 section~~Section 8.402.32(A) through 8.402.32(D).

8.402.10 ADMISSION PROCEDURES FOR CLASS I NURSING FACILITIES

.11 The URC/Single Entry Pointy (SEP) shall certify a client for nursing facility admission after a client is determined to meet the functional level of care and passes the PASRR Level 1 screen requirements for ~~long term~~long-term care. However, the URC/SEP shall not certify a client for nursing facility admission unless the client has been advised of ~~long term~~long-term care options including Home and Community Based Services as an alternative to nursing facility care.

.12 The medically licensed provider must complete the necessary documentation prior to the client's admission.

.13 The ULTC 100.2 and other transfer documents concerning medical information as applicable, must accompany the client to the facility.

.14 The nursing facility or hospital shall notify the URC/SEP agency of the pending admission by faxing or emailing the appropriate form. The date the form is received by the URC/SEP agency shall be the effective start date if the client meets all eligibility requirements for Medicaid ~~long term~~long-term care services.

.15 The URC/SEP case manager shall determine the client's length of stay using the appropriate form developed by the Department. The length of stay shall be less than a year, one year or indefinite. All indefinite lengths of stay shall be approved by the case manager's supervisor.

.16 The URC/SEP agency shall notify in writing all appropriate parties of the initial length of stay assigned. Appropriate parties shall include, but are not limited to, the client or the client's designated representative, the attending physician, the nursing facility, the Fiscal Agent, the appropriate County Department of Social/Human Services, the appropriate community agency, and for clients within the developmentally disabled or mentally ill target groups, the Department of Human Services or its designee.

.17 The nursing facility shall be responsible for tracking the length of stay end date so that a timely reassessment is completed by the URC/SEP.

.18 The ~~Utilization Review Contractor~~URC will determine the start date for nursing facility services. The start date of eligibility for nursing facility services shall not precede the date that all the requirements (functional level of care, financial eligibility, disability determination) have been met.

8.402.30 ADMISSION PROCEDURES FOR HOME AND COMMUNITY BASED SERVICES

.31 When the client meets the level of care requirements for ~~long term~~long-term care, is currently living in the community, and could possibly be maintained in the community, the URC/SEP agency shall immediately communicate with the appropriate community agency, according to the URC/SEP agency-determined target group, for an evaluation for alternative services. The URC/SEP agency shall forward a copy of the worksheet plus a State prescribed disposition form to the agency either immediately after the telephone referral, or in place of the telephone referral.

.32 Based upon information obtained in the pre-admission review, the URC/SEP case manager shall make the referral to the appropriate community agency based on the client's target group designation, as defined below:

A. Individuals determined by the URC/SEP agency to be in the Mentally Ill target group, regardless of source, shall be referred to the appropriate community mental health center or clinic.

B. Individuals determined by the ~~Utilization Review Contractor~~URC to be in the Functionally Impaired Elderly target group or the Physically Disabled or Blind target group shall be referred to the appropriate Single Entry Point A~~a~~gency for evaluation for Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD).

C. Individuals identified by the ~~Utilization Review Contractor~~URC to be in the Developmentally Disabled target group shall be referred to the appropriate Community Centered Board.

D. Individuals determined by the ~~Utilization Review Contractor~~URC to be in the Persons Living with AIDS target group shall be referred to the appropriate ~~single entry point agency~~Single Entry Point Agency for evaluation for HCBS-EBD.

E. The ~~Utilization Review Contractor~~URC shall notify any clients referred to case management agencies of the referral, the provisions of the program, and shall inform them of the complaint procedures.

.33 The case management agency or community mental health center or clinic shall complete an evaluation for alternative services within five (5) working days of the referral by the ~~Utilization Review Contractor~~URC.

.34 Single Entry Point A~~a~~gencies shall conduct the evaluation in accordance with the procedures at ~~10 CCR 2505-10 section~~Sections 8.486 and 8.390.

.35 Community Centered Boards shall conduct the evaluation in accordance with procedures at ~~10 CCR 2505-10 section~~Section 8.500.

.36 Community mental health centers and clinics shall conduct the evaluation in accordance with Standards/Rules and Regulations for Mental Health 2 CCR 502-1 ~~section~~Section 21.940 and Rules and Regulations Concerning Care and Treatment of the Mentally Ill, 2 CCR 502-1 ~~section~~Section 21.280.

.37 If the community agency develops an approved plan for ~~long term~~long-term care services, the ~~Utilization Review Contractor~~URC will approve one (1) certification for ~~long term~~long-term care services and the client shall be placed in alternative services. Following receipt of the fully completed ULTC ~~100.2,~~ the ~~Utilization Review Contractor~~URC will review the information submitted and make a certification decision. If certification is approved, the ~~Utilization Review Contractor~~URC shall assign an initial length of stay for alternative services. If certification is denied, the decision of the ~~Utilization Review Contractor~~URC may be appealed in accordance with ~~10 CCR 2505-10 section~~Section 8.057 through 8.057.8.

.38 If the appropriate community agency cannot develop an approved plan for ~~long term~~long-term care services, the ~~Utilization Review Contractor~~URC will approve certification for ~~long term~~long-term care services and utilize the procedure for nursing home admissions described previously in this section.

8.402.40 ADMISSION TO NURSING FACILITY WITH REFERRAL FOR COMMUNITY SERVICES

.41 When a client who meets the level of care requirements for ~~long term~~long-term care is currently hospitalized but could possibly be maintained in the community, certification shall be issued. The client may be placed in the nursing facility, given a short length of stay and immediately referred to the appropriate community agency for evaluation for alternative services in accordance with the procedure described in the preceding section.

8.402.50 DENIALS (ALL TARGET GROUPS)

.51 When, based on the pre-admission review, the client does not meet the level of care requirements for skilled and maintenance services, certification shall not be issued. The client shall be notified in writing of the denial.

.52 If the ~~Utilization Review Contractor~~URC denied ~~long term~~long-term care certification based upon the information on the ULTC 100.2, written notification of the denial shall be sent to the client, the attending physician, and the referral source (hospital, nursing facility, etc.).

If the information provided on the ULTC 100.2 indicates the client does meet the level of care requirements, the ~~Utilization Review Contractor~~URC shall proceed with the admission and/or referral procedures described above.

.53 Denials of certification for ~~long term~~long-term care may be appealed in accordance with the procedures described at ~~10 CCR 2505-10 section~~Section 8.057 through 8.057.8.

.54 Denial of designation into a specifically requested target group may also be appealed in accordance with ~~10 CCR 2505-10 section~~Section 8.057 through 8.057.8.

8.402.60 CONTINUED STAY REVIEWS: SKILLED AND MAINTENANCE SERVICES

.61 The ~~Utilization Review Contractor~~URC shall authorize all skilled nursing facility and intermediate care facility services, Home and Community Based Services for the Elderly, Blind and Disabled, and mental health clinic services when such services are appropriate and necessary for eligible clients. The ~~Utilization Review Contractor~~URC may also limit the period for which covered ~~long term~~long-term care services are authorized by specifying finite lengths of stay, and may perform periodic continued stay reviews, when appropriate, given the eligibility, functional and diagnostic status of any eligible Client.

.62 Continued S~~s~~tay R~~r~~eviews shall, at a minimum, be conducted as frequently as necessary for the purpose of reviewing and re-establishing eligibility for all Home and Community Based Services waiver programs, in accordance with all applicable statutes, regulations and federal waiver provisions.

.63 The frequency of the continued stay reviews and the determination of length of stay for nursing facilities may be conducted for the purpose of program eligibility. The process for these decisions will be prescribed in criteria developed by the Department.

.64 Continued S~~s~~tay R~~r~~eviews for ~~long term~~long-term care clients receiving HCBS-EBD or mental health clinic services may be conducted more frequently at the request of the case manager, client, authorized representative, or the behavioral health organization.

.65 The Continued Stay Review will follow the same procedures found at ~~section~~Section 8.401.11-.17(H) and if applicable, ~~section~~Section 8.485.61(B)(3).

.66 As a result of the C~~c~~ontinued S~~s~~tay R~~r~~eview, the ~~Utilization Review Contractor~~URC shall renew or deny certification.

8.403 LONG TERM CARE ~~-~~ SERVICES ~~TO THE DEVELOPMENTALLY DISABLED~~FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

~~Long term~~Long-term care services for ~~the developmentally disabled~~ individuals with intellectual or developmental disabilities include institutional services available through ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities (~~ICF/IID~~)~~ and Home and Community Based Services for ~~the Developmentally Disabled~~individuals with Developmental Disabilities (HCBS-DD). These specialized services are available to Medicaid eligible clients who meet the target group designation for ~~the developmentally disabled~~individuals with developmental disabilities~~,~~ and meet the level of care guidelines described below.

8.403.1 LEVEL OF CARE GUIDELINES FOR ~~LONG TERM~~LONG-TERM CARE SERVICES FOR T~~HE DEVELOPMENTALLY DISABLED~~INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

Level of care guidelines for programs for ~~the developmentally disabled~~ individuals with intellectual or developmental disabilities are used to determine if the profile of a client's programmatic and/or medical needs are appropriate to a specific ICF/IID nursing home class or equivalent set of HCBS-DD services.

.11 Clients shall be certified for admission to a specific class of ICF/IID ~~or equivalent set of HCBS-DD services~~ based on the following criteria:

A. Minimum/Moderate - ~~developmentally disabled clients~~individuals with intellectual or developmental disabilities who exhibit the following characteristics:

1. Have deficiencies in adaptive behavior that preclude independent living and require a supervised ~~sheltered~~ living environment;

2. Need supervision and training in self~~-~~help skills and activities of daily living, but do not display excessive behavior problems which are disruptive to other residents or which prevent participation in group or community activities;

3. Are capable of attending appropriate day services or engaging in ~~sheltered~~supported or competitive employment; and,

4. Are capable of being maintained in a community-based setting.

Clients certified at this level of care may be provided Class II ICF/IID services ~~or~~if ~~those~~ HCBS-DD services (as set forth in the regulations at ~~10 CCR 2505-10 section~~Section 8.500) are not available, after a reasonable search has been conducted by the CCB, due to lack of availability of appropriate providers.

B. Specialized Intensive~~- -~~ – individuals with intellectual or developmental~~ly~~ disabilities~~led individuals~~ whose psychological, behavioral, and/or developmental needs require 24-hour supervision, and who have potential for movement to a less restrictive living arrangement ~~within 24 months (on the average).~~. These individuals must conform to one of the profiles described below:

1. Behavior development profile:

- Function at a severe to moderate overall level of ~~retardation~~intellectual or developmental disability;

- May present a danger to self or others in the absence of supervision and habilitative services;

- Display severe maladaptive and/or anti-social behaviors, and may have exhibited delinquent behaviors;

- May display destructive or physically aggressive behaviors;

- Need specialized behavior management, counseling, and supervision;

2. Social emotional development profile:

- Function at a moderate to mild overall level of ~~retardation~~intellectual or developmental disability.

- Exhibit severe social and emotional problems attributable to a mental disorder.

- May be verbally abusive and/or physically aggressive toward self, others, or property.

- May display run-away, withdrawal, and/or bizarre behavior attributable to a mental disorder;

- Need social, adaptive, and intensive mental health services.

3. Intensive developmental profile:

- Function at a profound to severe level of intellectual or developmental disability;

- Exhibit severe deficiencies in behaviors such as eating, dressing, hygiene, toileting, and communication;

- May display inappropriate social and/or interpersonal behaviors;

- Need intensive self-management and adaptive behavior training.

Additionally, these individuals are capable of functioning in a community-based setting.

Clients certified at this level of care may be provided Class II or Class IV ICF/IID services ~~or those~~ if HCBS-DD services (as provided in the regulations at ~~10 CCR 2505-10 section~~Section 8.500) are not available, after a reasonable search has been conducted by the CCB, due to lack of availability of appropriate providers.

C. Intensive Medical/Psychosocial - ~~developmentally disabled individuals~~ individuals with intellectual or developmental disabilities who have intensive medical and psychosocial needs that require highly structured, in house, comprehensive, medical, nursing and psychological treatment. These individuals must meet at least one of the following requirements:

1. Exhibits extreme deficiencies in adaptive behaviors in association with profound or severe ~~retardation~~ intellectual or developmental disabilities or in association with medical problems requiring availability of medical life support services on a continuous basis; and/or

   Exhibits maladaptive behavior(s) potentially injurious to self or others to the degree that intensive programming in an institutional or closed setting is required; and

   Inappropriate for placement in less restrictive settings, such as minimum/moderate or specialized intensive community-~~-~~based services, due to the nature and/or severity of their ~~handicaps~~disabilities.

2. Appropriate for service in less restrictive community residential programs, but all local and statewide avenues for alternative placement have been investigated and exhausted prior to referral to a Class IV facility. Plans for eventual community placement have been established;

3. Committed by court action to a Regional Center under the Division ~~for Developmental Disabilities~~Regional Center Operations, Department of ~~Institutions~~Human Service~~r~~s.

Clients certified at this level of care may be provided Class IV ICF-~~MR~~IID services ~~or~~if HCBS-DD services (as provided in the regulations at ~~10 CCR 2505-10 section~~Section

8.500) are not available after a reasonable search has been conducted by the CCB, due to lack of availability of appropriate providers.

8.404 ADMISSION CRITERIA: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

8.404.1 Clients needing ICF/IID ~~and HCBS/DD~~ level of care are those who:

A. Require aggressive and consistent training to develop, enhance or maintain skills for independence (e.g., on-going reliance on supervision, guidance, support and reassurance); or

B. Are generally unable to apply skills learned in training situations to other settings and environments; or

C. Generally cannot take care of most personal care needs, cannot make basic needs known to others, and cannot understand simple commands, (e.g., requires assistance or prompts in bathing and/or dressing, neglects to wear protective clothing, does not interact appropriately with others, speaks in muffled/unclear manner, fails to take medications correctly, confuses values of coins, spends money inappropriately); or

D. Are unable to work at a competitive wage level without support, (e.g., specially trained managers, job coach, or wage supplements) and are unable to engage appropriately in social interactions (e.g., alienates peers by teasing, arguing or being cruel, does not make decisions); or

E. Are unable to conduct themselves appropriately when allowed to have time away from the facility's premises (e.g., loses self-control when s/he cannot get what s/he wants, performs destructive acts, unsafe crossing streets or following safety signs) or

F. Have behaviors that would put self or others at risk for psychological or physical injury.

.11 Clients needing placement in an ICF/IID are those who require an active treatment program. An active treatment program is defined as the aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

A. The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

B. The prevention or deceleration of regression or loss of current optimal functional status.

~~.12Clients needing placement in the HCBS/DD program are those who require an active habilitation program. Active habilitation is determined by assessing that the quantity, quality, and importance of a client's opportunities for independence, social integration, and responsible decision making are being provided consistent with his/her needs and directed toward:~~

~~A.The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and~~

~~B.The prevention or deceleration of regression or loss of current optimal functional status.~~

8.404.2 CONTINUED STAY REVIEW CRITERIA: PROGRAMS FOR ~~THE DEVELOPMENTALLY DISABLED~~INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

Same as admission criteria unless the individual needs the help of an ICF/IID to continue to function independently because s/he has learned to depend upon the programmatic structure it provides. The fact that s/he is not yet independent, even though s/he can be, makes it appropriate for s/he to receive active treatment services directed at achieving needed and possible independence.

8.404.3 Adherence to the following sections of CDPHE and/or ~~Division for Developmental Disabilities~~ Department of Health Care Policy and Financing rules and regulations are critical to the provision of active treatment and active habilitation:

A. Assessments

B. Individual habilitation plans

C. Individual program plans

D. Community integration

E. Independence training

F. Behavior management

G. Psychotropic medication use

For individuals needing placement in the ICF/IID facility ~~and HCBS/DD Program~~, a list of specific services or interventions needed in order to make progress must be provided.

8.405 ADMISSION PROCEDURES: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

.10 PREADMISSION REVIEW

For admission to ICF/IID facilities ~~or the provision of services through programs of Home and Community Based Services for the Developmentally Disabled (HCBS-DD), Developmentally Disabled~~ clients must be evaluated by the ~~Residential Referral/ Placement Committee (RR/PC) serving the~~ Community Centered Board (CCB) in the area where the client resides. If services will be provided through a CCB in another area, the client shall be evaluated by that area's ~~RR/PC~~CCB.

The client shall be referred by the ~~RR/PC~~CCB to the ~~Utilization Review Contractor~~URC for admission review and to the appropriate County Department of Social/Human Services for determination of Medicaid eligibility. The ~~Utilization Review Contractor~~URC shall not determine admission certification under Medicaid for any ~~Developmentally Disabled~~intellectually or developmentally disabled client in the absence of a referral from the ~~RR/PC~~CCB except for emergency admissions to the Class I facilities.

.11 The ~~RR/PC~~CCB evaluation must contain background information as well as currently valid assessments of functional, developmental, behavioral, social, health, and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

.12 ~~RR/PC~~CCB ADVERSE RECOMMENDATION

In cases where the ~~RR/PC~~CCB declines to recommend placement of a ~~developmentally disabled individual~~ client into an ICF/IID facility ~~or equivalent HCBS-DD services~~, the ~~RR/PC~~CCB shall inform the client of the recommendation using the HCBS-DD-21 f~~F~~orm. The ~~RR/PC~~CCB shall

also notify the client or the client's designated representative of the client's right to request a formal ~~Utilization Review Contractor~~URC level of care review.

The client shall have thirty (30) days from the postmark date of the notice to request a formal ~~Utilization Review Contractor~~URC review. If the client requests a formal ~~Utilization Review Contractor~~URC level of care review, the ~~RR/PC~~ CCB shall submit the required documentation plus any new documentation submitted by the client to the ~~Utilization Review Contractor~~URC. The ~~Utilization Review Contractor~~URC shall review and make a level of care determination in accordance with the admission procedures below.

8.405.2 ADMISSION PROCEDURES FOR ICF/IID FACILITIES

.21 When the client, based on ~~RR/PC~~CCB review, cannot reasonably be expected to make use of ICF/IID or ~~Home and Community Based Services for the Developmentally Disabled~~HCBS-DD , the ~~RR/PC~~ CCB shall notify the physician and the ~~Utilization Review Contractor~~URC. The physician and the ~~Utilization Review Contractor~~URC/Community Center Board (URC/CCB) agency then proceed with the SNF or ICF placement under the provisions set forth at ~~10 CCR 2505-10 section~~Section 8.402.10~~. through 10 CCR 2505-10 section~~Section ~~8.402.16~~.

22 When the ~~RR/PC~~CCB determines that a client is not appropriately served through HCBS-DD services or, in accordance with provisions permitting the client or the client's designated representative to choose institutional services as an alternative to HCBS-DD services, the ~~RR/PC~~CCB shall recommend placement to an ICF/IID facility. The ~~RR/PC~~CCB shall seek the approval of the client's physician. The physician shall notify the URC/CCB agency of the proposed placement. Based on information provided by the ~~RR/PC~~CCB and the client's physician, the URC/SEP agency may certify the client for ~~long term~~long-term care prior to ICF/IID admission.

.23 The URC/CCB agency shall advise the County Department of Social/Human Services of the certification to enable the County Department staff to assist with the placement arrangements.

24. The ULTC-100.2 and other transfer documents concerning medical information as applicable must accompany the client to the facility.

.25 Following receipt of the fully completed ULTC 100.2, the URC/CCB shall review the information and make a final certification decision. If certification is approved, the URC/CCB shall assign an initial length of stay according to ~~10 CCR 2505-10 section~~Section 8.404.1. If certification is denied, the decision of the URC/CCB may be appealed in accordance with the appeals process at 10 CCR 2505-10 ~~section~~Section 8.057.

8.405.30 ADMISSION PROCEDURES FOR ~~THE HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (~~HCBS-DD~~)~~

.31 ~~RR/PC~~CCB~~'s~~s may evaluate clients for HCBS-DD services if, in the judgment of the CCB~~RR/PC~~, such services represent a viable alternative to SNF, ICF, or ICF/IID services. The evaluation shall be carried out in accordance with the procedures set forth in 2 CCR ~~section~~Section 503-1.

.32 If the ~~RR/PC~~CCB recommends HCBS-DD placement, then the URC/CCB will approve certification for services for the developmentally disabled at the level of care recommended by the ~~RR/PC~~ CCB. The client will be placed in alternative service.

Following receipt of the completed ULTC 100.2 and any other supporting information, the URC/CCB will review the information and make a final certification determination.

If certification is approved, the URC/CCB shall assign an initial length of stay for HCBS-DD services.

If certification is denied, the decision of the URC/CCB may be appealed in accordance with ~~section~~Section 8.057.

8.405.4 CONTINUED STAY REVIEW PROCEDURES; SERVICES FOR ~~THE DEVELOPMENTALLY DISABLED~~INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

.41 Continued S~~s~~tay ~~r~~Reviews shall be conducted by the ~~Utilization Review Contractor~~URC for all intellectually and ~~developmentally disabled~~ clients in ICF/IID services, in ~~accordace~~accordance with 42 CFR Part 456 Subpart F.~~ The frequency of these reviews will be based on the length of stay assigned by the Utilization Review Contractor consistent with the following guidelines:~~

~~A.~~Minimum/Moderate Level of Care~~: No less than twelve months but no more than twenty-four months.~~

~~B.~~Specialized Intensive Level of Care~~: Twenty-four months.~~

~~C.~~Medical/Psychosocial Level of Care~~: No less than twelve months and no more than twenty-four months.~~

~~.42Continued stay reviews shall be conducted by the Utilization Review Contractor for all developmentally disabled clients in HCBS-DD services at least annually.~~

~~.43Continued stay reviews may be conducted more frequently at the request of the Community Centered Board case manager.~~

.4~~4 2~~As a result of the ~~c~~Continued S~~s~~tay R~~r~~eview, the ~~Utilization Review Contractor~~URC shall renew or deny certification.

8.408.76 REVIEW OF STATE DEPARTMENT ACTION

Disagreements with the decisions and recommendations of the Review Team may be adjudicated through the Administrative Review mechanism of the Department; however, the ~~Division of Medical Assistance~~Department will retain the right to final decision.

8.409.56 REVIEW OF STATE DEPARTMENT ACTION

Disagreements with the decisions and recommendations of the Review Team may be adjudicated through the Administrative Review mechanism of the Department; however, the ~~Division of Medical Services~~ Department will retain the right to final decision.

8.423 VISITS TO RECIPIENTS BY THE COLORADO ~~LONG TERM~~LONG-TERM CARE OMBUDSMAN AND DESIGNATED REPRESENTATIVES

A. Definitions:

Designated Representatives - are persons who have been specifically appointed by the Colorado Ombudsman to be an official part of the statewide ombudsman program.

Such designated representatives shall receive a minimum of twenty (20) hours of training using the manual provided by the Colorado ~~Long Term~~Long-term Care Ombudsman Program as well as other materials. Included in this training shall be material regarding the rights of patients and

specifically procedures which protect the confidentiality of information regarding Medicaid patients.

Official Colorado Ombudsman Program - the agency which has received the Ombudsman grant from the Older Americans Act through the Colorado Department of Human Services is for purposes of this regulation considered to be the official State Ombudsman Program.

B. The Colorado Ombudsman and designated representatives shall have access to the physical premises of nursing home facilities and the Medicaid residents of these facilities. Visits to the nursing home should be during reasonable hours except in instances where the nature of a complaint investigation requires visitation during off hours.

All designated representatives (after they have completed the necessary training) will be provided with identification showing them to be a part of the State Ombudsman Program. Under normal circumstances such identifications will be presented to the nursing home administrator or person in charge during the administrator's absence.

C. The Colorado Ombudsman or designees shall only disclose information received from a Medicaid patient's records and/or files when:

1. The Ombudsman authorizes the disclosure and

2. In cases of identifying a patient, the patient or the legal representative of the patient must consent in writing to the disclosure and specify to whom the identity may be disclosed or

3. A court orders the disclosure.

D. Non-compliance with the provisions of this ~~section~~Section of the regulation will not be considered sufficient good cause as defined in ~~10 CCR 2505-10~~ ~~section~~Section 8.130.4.

8.430.3 NEW NURSING FACILITY CERTIFICATION

8.430.3.A. Procedures and Criteria for Medicaid Certification of a New Nursing Facility

1. The burden of demonstrating the need for a new Medicaid facility shall be entirely on the applicant.

2. The applicant for Medicaid certification of a new nursing facility shall:

a. File a letter of intent to apply for certification with the Department in January or July of the year in which the application will be filed. The letter of intent shall specify:

i) The person or corporation who will submit the application.

ii) The proposed service area.

iii) The number of beds in the new facility for which Medicaid approval will be requested.

b. No later than five months from the date of filing the letter of intent, the applicant shall submit a complete application. The application shall include:

i) The name, address and phone number of the person or corporation requesting approval for the new nursing facility.

ii) The total number of proposed beds and the number of beds requested for Medicaid certification.

iii) A description of the service area and justification that the service area can be reasonably served by the new nursing facility.

iv) If construction of the additional beds or the new nursing facility has not been completed by the date the application is filed, the following documentation shall also be provided:

1) Official written documentation showing ownership of the proposed new nursing facility.

2) Location of the proposed new nursing facility including documentation of ownership, lease or option to buy the land.

3) Documentation from a financial institution regarding financing support for the new nursing facility.

4) Complete, written documentation that preliminary architectural plans for the proposed new nursing facility have been submitted to CDPHE.

5) Expected completion date of the new nursing facility.

v) A statement regarding any previous contracts with or enrollment in any state's Medicaid program. The statement shall assure that the applicant has never been found guilty of fraud or been decertified from participation in the Medicaid program in Colorado or any other state.

3. A completed application shall be made available on the Department's Internet website for public review and comment. In addition, the applicant shall provide newspaper notice at the applicant's expense, that the application has been submitted. A public hearing on the application may be conducted.

4. As a condition of approval, the new provider may be required to execute an appropriate performance agreement.

5. Approval or denial of an application for Medicaid certification of a new nursing facility shall be based on the following information from the applicant:

a. Planned resident capacity and payer mix.

b. Planned differentiation of the proposed new facility from existing nursing facilities in the same service area (e.g., new models of care, special programs, or targeted populations).

c. The applicant's marketing plan, including planned communications and presentations to discharge personnel and placement agencies.

d. Demographic analysis of the applicant's designated service area, including a market analysis of other available ~~long term~~long-term care services, e.g., assisted living, home health, home and community~~-~~-based services, etc., and the extent to which such alternative services are utilized.

e. Projections of net patient revenue and operating costs.

f. Audited financial statements for the most recently closed fiscal year for the entity seeking Medicaid certification.

g. Additional financial, market or programmatic information requested by the Department within two months after the application date;

h. Historical information concerning the quality of care and survey compliance in other nursing facilities owned or managed by the applicant or a related entity or individual.

i. A statement assuring cooperation with de-institutionalization and community placement efforts.

j. Documentation of whether the proposed new facility provides needed beds to an underserved geographical area, as described in ~~10 CCR 2505-10 section~~Section 8.430.3.A.5.j.i.~~)~~, or to an underserved special population, as described in ~~10 CCR 2505-10 section~~Section 8.430.3.A.5.j.ii~~)~~.

i) To qualify as an underserved geographical area of the state, the application must demonstrate, with appropriate documentation, that:

1) The new nursing facility is located in the service area defined by the application. The service area shall be no more than two contiguous counties in the state.

2) The service area shall have a nursing facility bed to population ratio of less than 40 beds per 1,000 persons over the age of 75 years.

a) The population projections shall be based upon statistics issued by the State Department of Local Affairs.

b) The applicable statistics for applications involving beds for which construction is complete at the time of application shall be the population statistics for the period including the date on which the application is filed.

c) The applicable statistics for applications involving beds for which construction is not complete at the time of application shall be the population projections for the expected date of completion of the beds set forth in the application.

3) The occupancy of existing nursing facilities in the proposed service area exceeds ninety percent (90%) for the six (6) months preceding the filing date of the application, as demonstrated by the nursing facility quarterly census statistics maintained by CDPHE.

ii) An application for a new nursing facility to serve an underserved special population shall contain the following information and documentation:

1) A description of the special populations to be served and why they cannot be served in the community.

2) Justification for the service area to be served.

3) A determination of whether there are existing excess beds in the proposed service area and, if so, why the existing excess beds cannot be used by or converted for use by the special populations.

a) The determination of existing excess beds shall include a population ratio analysis and occupancy analysis as set forth in ~~10 CCR 2505-10 section~~Section 8.430.3.A.5.j.i.~~)~~, and shall be calculated by utilizing the formulas, methods and statistics set forth therein.

b) The justification of why existing excess beds cannot be used for or converted for use by the special populations(s) must be clearly demonstrated and supported by relevant and competent evidence.

4) Applications based on underserved special populations must document that one or more of the following special populations is underserved in the proposed service area:

a) Clients with AIDS.

b) Clients with mental, ~~or~~ intellectual or developmental disabilities, as defined by the Preadmission Screening and Annual Resident Review (PASRR) process described at ~~10 CCR 2505-10 section~~Section 8.401.18~~ et seq~~.

c) Clients with a traumatic head injury.

d) Clients who have been certified for a hospital level of care in accordance with ~~10 CCR 2505-10 section~~Section 8.470.

5) The following requirements also apply to approval of new nursing facilities for special populations:

a) The Statewide ~~Utilization Review Contractor~~URC shall certify ~~long-term~~long-term care prior authorization requests for Medicaid clients who are verified as meeting the special populations definitions provided in ~~10 CCR 2505-10 section~~Section 8.430.3.A.5.j.ii.4.

b) In the case of applications for approval of new nursing facilities for individuals with intellectual or developmental disabilities~~mentally disabled populations~~, all restrictions concerning Medicaid reimbursement described at ~~10 CCR 2505-10 section~~Section 8.401.41 et seq., Guidelines for Institutions for Mental Diseases (IMD's), shall apply.

6) A bed approved for a specific underserved special population shall not be used for any other population, even if a Medicaid client occupying this type of bed is discharged or experiences a change in physical condition which requires transfer to a general skilled nursing unit bed.

reimbursement for class I nursing facilities.

8.443.2 NURSING FACILITY CLASSIFICATIONS

1. Class I facilities are those facilities licensed and certified to provide general skilled nursing facility care.

2. Class II (ICF/IID) facilities are those facilities whose program of care is designed to ~~treat developmentally disabled~~ provide services for individuals with intellectual or developmental disabilities ~~whose medical and psychosocial needs are best served by receiving care in a community setting~~w~~.~~ho have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program.

   a. Class II (ICF/IID) facilities shall provide care and services designed to maximize each resident's capacity for independent living and shall seek out and utilize other community programs and resources to the maximum extent possible according to the needs and abilities of each individual resident.

   b. Class II (ICF/IID) facilities serve persons whose medical and psychosocial needs require services in an institutional setting and are expected to provide such services in an environment which approximates a home-like living arrangement to the maximum extent possible within the constraints and limitations inherent in an institutional setting.

   c. Class II (ICF/IID) facilities shall be certified in accordance with 42 C.F.R. part 442, Subpart C, and 42 C.F.R. part 483 and shall be licensed by CDPHE. Class II facilities shall provide care and a program of services consistent with licensure and certification requirements.

3. Class IV (ICF/IID) facilities are those facilities whose program of care is designed to treat developmentally disabled individuals who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program.

a. Class IV (ICF/IID) facilities shall offer full-time, 24-hour interdisciplinary and professional treatment by staff employed at such facility. Staff must be sufficient to implement and carry out a comprehensive program to include, but not necessarily be limited to, care, treatment, training and education for each individual.

b. Class IV (ICF/IID) facilities shall be certified in accordance with 42 C.F.R. part 442, Subpart C, and 42 C.F.R. part 483 and shall be licensed by CDPHE. Class IV facilities shall provide care and a program of services consistent with licensure and certification requirements.

c. State-administered, tax-supported facilities are not subject to the maximum reimbursement provisions and do not earn an incentive allowance.

d. Private, non-profit or proprietary facilities that are not tax-supported or state-administered are subject to the maximum reimbursement provisions and may earn an incentive allowance.

8.443.3 IMPUTED OCCUPANCY FOR CLASS II ~~AND PRIVATELY OWNED CLASS IV~~ FACILITIES

8.443.3.A. The Department or its designee shall determine the audited allowable costs per patient day.

1. The Department shall utilize the total audited patient days on the MED-13 unless the audited patient days on the MED-13 constitute an occupancy rate of less than 85 percent of licensed bed day capacity when computing the audited allowable cost per patient day for all rates.

2. In such cases, the patient days shall be imputed to an 85 percent rate of licensed bed day capacity for the nursing facility and the per diem cost along with the resulting per diem rate shall be adjusted accordingly except that imputed occupancy shall not be applied in calculating the facility's health care services and food costs.

3. The licensed bed capacity shall remain in effect until the Department is advised that the licensed bed capacity has changed through the filing of a subsequent cost report.

4. The imputed patient day calculation shall remain in effect until a new rate from a subsequent cost report is calculated. Should the subsequent cost report indicate an occupancy rate of less than 85 percent of licensed bed day capacity, the resulting rate shall be imputed in accordance with the provisions of this section.

8.443.3.B. Nursing facilities located in rural communities with a census of less than 85 percent shall not be subject to imputed occupancy. A nursing facility in a rural community shall be defined as a nursing facility in:

1. A county with a population of less than fifteen thousand; or

2. A municipality with a population of less than fifteen thousand which is located ten miles or more from a municipality with a population of over fifteen thousand; or

3. The unincorporated part of a county ten miles or more from a municipality with a population of fifteen thousand or more.

8.443.3.C. Any nursing facility that has a reduction in census, causing it to be less than 85 percent, resulting from the relocation of mentally ill or developmentally disabled residents to alternative facilities pursuant to the provisions of the Omnibus Reconciliation Act of 1987 shall:

1. Be entitled to the higher of the imputed occupancy rate or the median rate computed by the Department for two cost reporting periods.

2. The imputed occupancy calculation shall be applied when required at the end of this period.

8.443.3.D. Imputed occupancy shall be applied to a new nursing facility as follows:

1. A new nursing facility means a facility not in the Colorado Medicaid program within thirty days prior to the start date of the Medicaid provider agreement.

2. For the first cost report submitted by a new facility, the facility shall be entitled to the higher of the imputed rate or the median rate computed by the Department.

3. For the second cost report submitted by a new facility, imputed occupancy shall be applied but the rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in the median computation.

4. For the third cost report and cost reports thereafter, imputed occupancy shall be applied without exception.

8.443.3.E. Nursing facilities undergoing a state-ordered change in case mix or patient census that significantly reduces the level of occupancy in the facility shall:

1. Be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department for two cost reporting periods.

2. At the end of this period, the imputed occupancy calculation shall be applied when required.

8.443.4 INFLATION ADJUSTMENT

8.443.4.A For class I nursing facilities, the per diem amount paid for direct and indirect health care services and administrative and general services costs shall include an allowance for inflation in the costs for each category using a nationally recognized service that includes the federal government's forecasts for the prospective Medicare reimbursement rates recommended to the United States Congress. Amounts contained in cost reports used to determine the per diem amount paid for each category shall be adjusted by the percentage change in this allowance measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

1. The percentage change shall be rounded at least to the fifth decimal point.

2. The index used for this allowance will be the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. The latest available publication prior to July 1 rate setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1, and June 30.

8.443.4.B For class II ~~and privately-owned class IV~~ facilities , at the beginning of each facility's new rate period, the inflation adjustment shall be applied to all costs except provider fees, interest, and costs covered by fair rental allowance.

1. The inflation adjustment shall equal the annual percentage change in the National Bureau of Labor Statistics Consumer Price Index (U.S. city average, all urban consumers), from the preceding year, times actual costs (less interest expense and costs covered by the fair rental allowance) or times reasonable cost for that class facility, whichever is less.

2. The annual percentage change in the National Bureau of Labor Statistics Consumer Price Index shall be rounded at least to the fifth decimal point.

3. The price indexes listing in the latest available publication prior to the July 1 limitation setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1 and June 30.

4. The provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period.

8.443.5 ADMINISTRATIVE COST INCENTIVE ALLOWANCE FOR CLASS II AND ~~PRIVATELY OWNED~~ CLASS IV FACILITIES

8.443.5.A. If the nursing facility's combined audited administration, property, and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) cost per patient day is less than the maximum reasonable cost for administration, property and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) costs for the class, the provider will earn an incentive allowance.

8.443.5.B. The incentive allowance for class II ~~and privately owned class IV~~ facilities shall be calculated at 25 percent of the difference between the facility's audited inflation adjusted cost and the maximum reasonable cost for that class. The incentive allowance will not exceed 12 percent of the reasonable cost.8.443.5.C. No incentive allowance shall be paid on health care services, raw food, fair rental value allowance and leasehold costs.

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

8.443.7.A Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

   If a facility employee or a management company/home office employee or owner has dual health care and administrative duties, the provider must keep contemporaneous time records or perform time studies to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed,

total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation. Time studies used must meet the following criteria:

a. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

b. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

c. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

d. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

e. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

f. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.

Health Information Managers (Medical Records Librarians): Must work directly with the maintenance and organization of medical records.

Social Workers: Includes social workers, life enhancement specialists and admissions coordinators.

Central or Medical Supply personnel: Includes duties associated with stocking and ordering medical and/or central supplies.

Activity personnel: Personnel classified as “activities” must have a direct relationship (i.e., providing entertainment, games, and social opportunities) to residents. For instance, security guards and hall monitors do not qualify as activities personnel. Costs associated with security guards and hall monitors are classified as administrative and general.

3. If the provider’s chart of accounts directly identifies payroll taxes and benefits associated with health care versus administrative and general cost centers, the amounts directly identified will be appropriately allowed as either health care or administrative and general. If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be allocated to the cost centers (health care and administrative and general) based on total employee wages reported in those cost centers. The reporting method for payroll taxes and benefits by cost center is required to be consistent from year to year. When a

provider wishes to change its reporting method because it believes the change will result in more appropriate and a more accurate allocation, the provider must make a written request to the Department for approval of the change ninety (90) days prior to the end of that cost reporting period. The Department has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the Department approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods. The approval will be for a minimum ~~three year~~three-year period. The provider cannot change methods until the ~~three year~~three-year period has expired.

4. Personnel licensed to perform patient care duties shall be reported in the administrative and general cost center if the duties performed by these personnel are administrative in nature.

5. Non-prescription drugs ordered by a physician that are included in the per diem rate, including costs associated with vaccinations.

6. Consultant fees for nursing, medical records, registered dieticians, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.

7. Purchases, rental, depreciation, interest and repair expenses of health care equipment and medical supplies used for health care services such as nursing care, medical records, social services, therapies and activities. Purchases, lease expenses or fees associated with computers and software (including the associated training and upgrades) used in departments within the facility that provide direct or indirect health care services to residents. Dual purpose software that includes both a health care and administrative and general component will be considered a health care service.

8. Purchase or rental of motor vehicles and related expenses, including salary and benefits associated with the van driver(s), for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. An example of the dual-purpose vehicle is one used for both resident transport and maintenance activities.

9. Copier lease expense.

10. Salaries, fees, or other expenses related to health care duties performed by a facility owner or manager who has a medical or nursing credential. Note that costs associated with the Nursing Home Administrator are an administrative and general cost.

11. Related Party Management Fees and Home Office Costs

    Related party management fees and home office costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the related party which are listed in this section, may be included in the health care cost center equal to the actual costs incurred by the related party. Documentation supporting the cost and health care licenses must be maintained. Only salaries, payroll taxes and employee benefits associated with health care personnel will be considered as allowable in the health care cost center. No overhead expenses will be included. The amount allowable in the health care cost category will be calculated in one of two ways:

a. Keeping contemporaneous time logs in 15-minute increments supporting the number of hours worked at each facility.

b. Distributing the cost evenly across all facilities as follows: the amount allowable in each health care facility's health care costs shall be equal to the total salary, payroll taxes and benefits of the health care personnel divided by the number of facilities where the health care personnel worked during the year. For example, if a nurse's total salary, payroll taxes, and benefits total $80,000, and the nurse worked on five facilities during the year, $16,000 is allowable in each of the facility's health care costs.

Auditable documentation supporting the number of facilities worked on during the year must be maintained. Even if a related party exception is granted in accordance with ~~10 CCR 2505-10 section~~Section 8.441.5.I.4, no mark-up or profit will be allowed in the health care cost center, only supported actual costs.

Non-Related Party Management Fees

Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.

12. Professional liability insurance, whether self-insurance or purchased, loss settlements, claims paid and insurance deductibles.

13. Medical director fees.

14. Therapies and services provided by an individual qualified to provide these services under Federal Medicare/Medicaid regulations including:

Utilization review
Dental care, when required by federal law
Audiology
Psychology and mental health services
Physical therapy
Recreational therapy
Occupational therapy
Speech therapy

15. Nursing licenses and permits, disposal costs associated with infectious material (medical or hazardous waste), background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

16. Food Costs. Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

8.443.7.B CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM REIMBURSEMENT RATES (LIMIT)

For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for direct and indirect health care services and raw food, the state department shall establish an annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing

facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. The health care limit will be calculated as follows:

1. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

2. The MED-13 cost report shall be deemed filed if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before December 31.

3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of the limit, the Department may:

    a. Exclude part, or all, of a provider's MED-13.

    b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. measured from the midpoint of the reporting period to the midpoint of the payment-setting period.

4. The health care limit and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the median costs of direct and indirect health care services and raw food as determined by an array of all class I facility providers; except that, for state veteran nursing homes, the health care limit will be one hundred thirty percent (130%) of the median cost.

    a. In determining the median cost, the cost of direct health care shall be case-mix neutral.

    b. Actual days of care shall be counted, not occupancy-imputed days of care, for purposes of calculating the health care limit.

    c. Amounts contained in cost reports used to determine the health care limit shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

        i). The percentage change shall be rounded at least to the fifth decimal point.

        ii). The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

6. Annually, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

7. The health care limit for health care reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.7.C. CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

For the fiscal year beginning July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent (8%) per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

8.443.7.D. CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND MEDICAID CASE MIX INDEX (CMI):

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. This payment shall not exceed the health care limit described at ~~10 CCR 2505-10 section~~Section 8.443.7B. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's Medicaid residents on a quarterly basis

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:

   a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.

   b. The facility's Medicaid resident acuity case mix index shall be a two-quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two-quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.

   c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.

   d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.

e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.

f. The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.

2. The annual facility specific direct health care maximum reimbursement rate shall be determined as follows:

a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

b. The statewide health care maximum allowable reimbursement rate (calculated at ~~10 CCR 2505-10 section~~Section 8.443.7B) shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.

c. The facility specific maximum reimbursement rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.

3. The annual facility specific indirect health care maximum allowable reimbursement shall be determined as follows:

a. The percentage of the indirect health care per diem cost to total health care cost shall be determined by dividing the indirect health care per diem cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

b. The facility specific in direct health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.

4. The case mix reimbursement rate component shall be determined as follows:

a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.

b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall the case mix reimbursement rate component.

5. The indirect health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

8.443.7.E DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV (ICF/IID) FACILITIES

1. For class II (ICF/IID) facilities, one hundred twenty-five percent (125%) of the median actual costs of all class II (ICF/IID) facilities;

2. For non-state administered class IV (ICF/IID) facilities, one hundred twenty-five percent (125%) of the median actual costs of all class IV (ICF/IID) facilities.

3. State-administered class IV (ICF/IID) facilities shall not be subject to the health care limit. The Med-13s of the state-administered class IV (ICF/IID) facilities shall be included in the health care limit calculation for other class IV (ICF/IID) facilities.

4. The determination of the reasonable cost of services shall be made every 12 months.

5. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed in accordance with these regulations, by each facility on or before May 2.

6. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2nd.

7. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

   a. Exclude part, or all, of a provider's MED-13; or

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report.

8. State-administered class IV (ICF/IID) facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV (ICF/IID) facilities shall be included in the maximum rate calculation for other class IV (ICF/IID) facilities.

9. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

10. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.8 REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

8.443.8.A. Administration Costs means the following categories of reasonable, necessary and patient-related costs:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other

clerical help, hall monitors, security guards, janitorial and plant staff and food service staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records or perform a time study in order to properly allocate their salaries between cost centers. Time studies used must meet the criteria described in ~~10 CCR 2505-10~~ ~~section~~Section 8.443.7.A.1.

2. Any portion of other staff costs directly attributable to administration.

3. Advertising and public relations.

4. Recruitment costs and staff want ads for all personnel.

5. Office supplies.

6. Telephone costs.

7. Purchased services: accounting fees, legal fees; computer network infrastructure fees. Computers and software used in administrative and general departments.

8. Management fees and home office costs, except as described in ~~10 CCR 2505-10~~ ~~section~~Section 8.443.7.A.13.

9. Licenses and permits (except health care licenses and permits) and training for administrative personnel, dues for professional associations and organizations.

10. All business-~~-~~related travel of facility staff and consultants, except that required for transporting residents to activities or for medical purposes.

11. Insurance, including insurance on vehicles used for resident transport, is an administrative cost. The only exception is professional liability insurance, which is a health care cost.

12. Facility membership fees and dues in trade groups or professional organizations.

13. Miscellaneous general and administrative costs.

14. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.

15. Purchases (including depreciation and interest), rentals, repairs, betterments and improvements of equipment utilized in administrative departments, including but not limited to the following:

    Resident room furniture and decor, excluding beds and mattresses
    Office furniture and décor
    Dining room and common area furniture and décor
    Lighting fixtures
    Artwork
    Computers and related software used in administrative departments

16. Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below.

17. All other reasonable, necessary and patient-related costs which are not specifically set forth in the description of “health care services” above, and which are not property, room and board, food or capital-related assets.

18. Background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

19. Provider fees for Class II and Class IV facilities.

8.443.8.B Property costs include:

1. Depreciation costs of non-fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).

2. Rental costs of non-fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).

3. Property taxes.

4. Property insurance.

5. Mortgage insurance.

6. Interest on loans associated with property costs covered in this section.

7. Repairs, betterments and improvements to property not covered by the fair rental allowance.

8. Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by the regulations regarding expensing of items.

8.443.8.C Room and board includes:

1. Dietary, other than raw food, and salaries related to dietary personnel including tray help, except registered dieticians which are health care.

2. Laundry and linen.

3. Housekeeping.

4. Plant operation and maintenance (except removal of infectious material or medical waste which is health care).

5. Repairs, betterments and improvements to equipment related to room and board services.

8.443.8.D Determination of the Administrative and General Maximum Allowable Rate (Limit) for Class II and IV (ICF/IID) Facilities.

The determination of the reasonable cost of services shall be made every 12 months. The maximum allowable reimbursement of administration, property and room and board costs, excluding raw food, land, buildings and fixed equipment, shall not exceed:

1. For class II (ICF/IID) facilities, one hundred twenty percent (120%) of the median actual costs of all class II facilities.

2. For class IV (ICF/IID) facilities, one hundred twenty percent (120%) of the median actual costs of all class IV (ICF/IID) facilities.

3. Determination of the rates beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before May 2.

4. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2.

5. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

   a. Exclude part, or all, of a provider's MED-13 or

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report to May 2.

6. State-administered class IV (ICF/IID) facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV (ICF/IID) facilities shall be included in the maximum rate calculation for other class IV (ICF/IID) facilities.

7. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

8. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.8.E. Class I Administrative and General Per Diem Reimbursement Rate

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the Department shall establish an annually readjusted schedule to pay each facility a reasonable price for the costs.

1. Determination of the class I rates beginning on July 1 each year shall utilize the most current MED-13 cost report submitted, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

2. The reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers.

3. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one

or more licensed beds, the reasonable price shall be one hundred five percent of the median per diem cost for all class I facilities.

4. In computing per diem cost, each nursing facility provider shall annually submit cost reports to the Department.

5. Actual days of care shall be counted rather than occupancy-imputed days of care.

6. The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation.

7. Amounts contained in cost reports used to establish this median shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc., measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

    a. The percentage change shall be rounded at least to the fifth decimal point.

    b. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8. The reasonable price determined at July 1, 2008 will be adjusted annually at July 1st for three subsequent years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

9. For each succeeding fourth year, the Department shall re-determine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

10. The reasonable price established by the median per diem costs determined each succeeding fourth year will be adjusted annually at July 1st for the three intervening years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

11. For fiscal years commencing on and after July 1, 2008, through the fiscal year commencing July 1, 2014, the state department shall compare a nursing facility provider's administrative and general per diem rate to the nursing facility provider's administrative and general services per diem rate as of June 30, 2008, and the state department shall pay the nursing facility provider the higher per diem amount for each of the fiscal years.

12. For fiscal years commencing on and after July 1, 2009, through the fiscal year commencing July 1, 2014, if a reallocation of management costs between administrative and general costs and the health care costs causes a nursing facility provider’s administrative and general costs to exceed the reasonable price established by the state department, the state department may pay the nursing facility provider the higher per diem payment for administrative and general services.

13. The reasonable price will be phased in over three years in accordance with the following schedule:

July 1, 2008	50% reasonable price
	50% cost-based rate
July 1, 2009	50% reasonable price
	50% cost-based rate
July 1, 2010	75% reasonable price
	25% cost-based rate
July 1, 2011	100% reasonable price

The phase in will allow a percentage of the reasonable price established in accordance with these rules (reasonable price) and a percentage of the July 1, 2008 administrative and general rate in accordance with the rules in effect prior to implementation of these rules (cost-based rate). The cost-based rate determined at July 1, 2008 will be adjusted annually at July 1st for two subsequent years. The cost-based rate shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8.443.8.F For the purpose of reimbursing class II (ICF/IID) ~~and privately-owned class IV~~ facilities a per diem rate for the cost of administrative and general services, the Department shall establish an annually readjusted schedule to reimburse each facility, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health care services costs and a fair rental allowance for capital-related assets.

1. In computing per diem cost, each class II and class IV (ICF/IID) facility provider shall annually submit cost reports to the Department.

2. The per diem reimbursement rate will be total allowable costs for administrative and general and health care services (actual or the limit per ~~10 CCR 2505-10 section~~Section 8.443.7.D) divided by the higher of actual resident days or occupancy imputed days per ~~10 CCR 2505-10 section~~Section 8.443.3.

3. An inflation adjustment per ~~10 CCR 2505-10 section~~Section 8.443.4B will be applied to the per diem administrative and general and health care reimbursement rates.

4. An incentive allowance for administrative and general costs may be included per ~~10 CCR 2505-10 section~~Section 8.443.5.

5. Each facility will be paid a per diem for capital-related assets per ~~10 CCR 2505-10 section~~Section 8.443.9.A.

8.443.13 RATE EFFECTIVE DATE

8.443.13.A For cost reports filed by Class 1 nursing facility providers, a July 1 Core Component per diem rate and subsequent adjusted Core Component per diem rates shall be established by the Department based on the last day of the cost reporting fiscal year end.

Core Component per diem rates shall be established as follows:

1. On July 1 in accordance with the table below.

2. On the first day of the 23rd month following the end of the facility's cost reporting period.

3. On the first day of the 6th month following the 23rd month rate effective date.

4. If the 23-month or 6-month rate coincide with July 1, only a July 1 and a January 1 rate shall be established

5. If the 6-month rate is after the July 1 rate set by the subsequent cost report, only a July 1 and 23-month rate shall be established.

Cost Report Fiscal Year End	July 1 Rate Effective Date	23 Month Rate Effective Date	6 Month Rate Effective Date
01/31/Year 1	07/01/Year 2	12/01/Year 2	06/01/Year 3
02/28/Year 1	07/01/Year 2	01/01/Year 3	(N/A)
03/31/Year 1	07/01/Year 2	02/01/Year 3	(N/A)
04/30/Year 1	07/01/Year 2	03/01/Year 3	(N/A)
05/31/Year 1	07/01/Year 3	04/01/Year 3	10/01/Year 3
06/30/Year 1	07/01/Year 3	05/01/Year 3	11/01/Year 3
07/31/Year 1	07/01/Year 3	06/01/Year 3	12/01/Year 3
08/31/Year 1	07/01/Year 3	(N/A)	01/01/Year 4
09/30/Year 1	07/01/Year 3	08/01/Year 3	02/01/Year 4
10/31/Year 1	07/01/Year 3	09/01/Year 3	03/01/Year 4
11/30/Year 1	07/01/Year 3	10/01/Year 3	04/01/Year 4
12/31/Year 1	07/01/Year 3	11/01/Year 3	05/01/Year 4

8.443.13.B For 12-month cost reports filed by the State-administered Class IV nursing ~~facilty~~facility (ICF/IID) providers, the rate shall be effective on the first day covered by the cost report.

8.443.13.C Any delay in completion of the audit of the MED-13 that is attributable to the provider, shall operate, on a time equivalent basis, to extend the time in which the Department shall establish the Schedule of Core Components Reimbursement Rates, under the provisions set forth in Section 8.443.13.A above.

8.443.13.D Delay in completion of the audit that is attributable to the provider shall include, but not be limited to, the following:

1. Failure of the provider to meet with the contract auditor at reasonable times requested by the auditor;

2. Failure of the provider to supply the contract auditor with information reasonably needed to complete the audit, including the Medicare cost report that the provider most recently filed with the Medicare fiscal intermediary or other Medicare information approved by the Department.

3. The time period that elapses during completion of the procedures described Section 8.442.1.

8.443.14 RATES FOR NEW FACILITIES

8.443.14.A. A new nursing facility means a facility:

1. That has not previously been certified for participation under Title XIX of the Social Security Act (42 U.S.C. section 1396r); or

2. That has not participated in Title XIX for a period in excess of 30 days prior to the effective date of the current Title XIX certification; or

3. That has changed from one class designation to another.

8.443.14.B. Nursing facilities that have undergone a transfer of ownership are not new nursing facilities provided the previous owner had participated in Title XIX in the last 30 days prior to ownership change.

8.443.14.C. A new nursing facility shall receive a per diem rate equal to the most recent average weighted rate for the appropriate nursing facilities class at the time the new facility begins business as a Medicaid provider.

1. This per diem rate shall remain in effect until a new rate is established based on the first cost report submitted as specified below.

2. The average weighted rate shall be calculated by the Department on the 30th of each month and shall not be revised when new rates are established which would retroactively affect the calculation.

3. The average weighted rate paid a new facility shall be adjusted on July 1 each year by the average weighted rate in effect on July 1.

8.443.14.D. New nursing facilities shall submit MED-13s during their initial year of operation as follows:

1. The first cost report shall be for a period covering the first day of operation through the facility's fiscal year end.

   a. If the first cost report for the period covers a period of 90 days or more, imputed occupancy shall be applied as described in ~~10 CCR 2505-10 section~~Section 8.443.3.A.

b. If the first cost report for the period covers a period of 90 days or more, the first cost report shall set the base for limitations on growth of allowable costs as described in ~~10 CCR 2505-10 section~~Section 8.443.11.A.

2. If the first cost report for the period specified above covers a period of 89 days or less, the facility's first cost report shall not be submitted until the next fiscal year end.

3. The next cost report shall be submitted for the twelve-month period following the period of the first cost report.

4. A new nursing facility shall advise the Department of the date its fiscal year will end and of the reporting option selected.

8.443.14.E. Imputed occupancy shall be applied to the first cost report submitted by a new class II ~~or privately owned class IV~~ (ICF/IID) facility. The facility shall be entitled to the higher of the imputed rate or the monthly weighted average rate computed by the Department.

8.443.14.F. Imputed occupancy shall be applied to the second cost report submitted by a new class II (ICF/IID) ~~or privately owned class IV~~ facility. The rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in median computation.

8.443.16 STATE-OPERATED ~~INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES~~ICF/IID (CLASS IV)

8.443.16.A State-operated ~~Intermediate Care Facilities for Individuals with Intellectual Disabilitie~~ICF/IID~~s~~ (class IV) shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services. Actual costs will be determined on the basis of information on the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

1. These costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period.

2. Reimbursement to state-operated Intermediate Care Facilities for Individuals with Intellectual Disabilities shall be adjusted retrospectively at the close of each twelve-month period.

3. The retrospective per diem rate will be calculated as total allowable costs divided by total resident days.

8.443.20 CLASS II AND CLASS IV (ICF/IID) NURSING FACILITY PROVIDER FEE

8.443.20.A. The Department shall charge and collect provider fees on services provided by all class II and class IV (ICF/IID) nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees and federal matching funds shall be used to sustain reimbursement for providing medical care under the state's medical assistance program for class II and class IV (ICF/IID) nursing facility providers.

1. Each class II and class IV (ICF/IID) nursing facility that is licensed in Colorado shall pay a fee assessed by the Department.

2. To determine the amount of the fee to assess pursuant to this section, the Department shall establish a fee rate on a per patient day basis.

a. The total annual fees due for class II and class IV (ICF/IID) nursing facilities will be calculated such that they do not exceed the federal limits as established in 42 C.F.R. section 433.68(f)(3)(i)(A), or five percent of the total costs for all class II and class IV nursing facilities, whichever is lower. 42 C.F.R. section 433.68(f)(3)(i)(A) (2013) is hereby incorporated by reference. The incorporation of 42 C.F.R. section 433.68(f)(3)(i)(A) excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request~~.~~.

b. The total annual fees will be divided by annual patient days for class II and class IV (ICF/IID) facilities from the most recently available MED-13 cost reports to establish the per patient day fee.

c. The Department may use estimated patient days in the per patient day fee calculation to adjust for expected changes in utilization.

d. When final audited MED-13 cost reports are available, the Department will review the fees charged during each state fiscal year to ensure that the fee amount was less than five percent of the total costs for all class II and class IV (ICF/IID) nursing facilities five percent statutory limit. If the fees were greater than five percent of the total costs for all class II and class IV (ICF/IID) nursing facilities, the Department will retroactively adjust the fees.

3. The Department shall calculate the fee to collect from each class II and class IV (ICF/IID) nursing facility by August 1 for the state fiscal year.

a. The Department shall notify the providers of their fee obligation in writing at least 30 days prior to due date of the fee.

b. The Department shall assess the provider fee on a monthly basis.

i. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed to the Department.

ii. The monthly fee is due by last day of the month for which the fee was assessed

iii. Fees may be paid through intragovernmental transfer, Automated Clearing House, or check.

8.444 through 8.446 Repealed, effective June 30, 2005

8.448 Repealed, effective May 30, 2006

8.449.1 REQUIREMENTS FOR UTILIZATION REVIEW

Utilization review requirements are that all ~~long term~~long-term health care facilities participating in the Medical Assistance Program make provision for utilization review and medical care appraisal to assure quality patient care and appropriate use of health care facilities. Each facility shall submit to the Department of ~~Human Services~~Health Care Policy and Financing a plan for doing so that agrees in principle with the model plan attached. Individual case reviews are to be so scheduled as to provide for

annual review of each patient certified for skilled nursing care and semi-annual review of each patient certified for intermediate care.

The Utilization Review Plan developed by the ~~long term~~long-term care facility lists the members of the Utilization Review Committee. Any change in membership of the Committee is to be communicated to the State Department of ~~Human Services~~Health Care Policy and Financing and the State Department of Public Health and Environment.

The minutes of Utilization Review Committee meetings are to be kept on file in the facility and available to representatives of the Department of ~~Human Services~~Health Care Policy and Financing and the State Department of Public Health and Environment.

8.449.2 USE OF FORMS AND COMMUNICATION CONCERNING RESULTS OF UTILIZATION REVIEW

Recommendations as to individual patients shall be recorded in duplicate on Forms MED-60. The original is filed with the committee minutes, the copy in the patient's administrative file.

When the U.R. Committee recommends a change in the level of care to be given to the patient, form letter Med-60A is completed in triplicate and sent to the patient's physician by the nursing home. If the attending physician agrees with the recommendations, he should date and sign the Med-60A and return it to the Nursing Home U.R. Committee. The nursing home shall then complete Form NH-8 to be sent, together with the Med-60A to the State Department of ~~Human Services~~Health Care Policy and Financing and to the county department. The original of Form Med-60A shall be kept in the patient's chart.

If the attending physician disagrees with the recommendations, he shall return the Form Med-60A with the reasons entered in the space provided, to the U.R. Committee. The U. R. Committee will review the reasons the physician did not accept the recommendations, and if valid, the classification will remain the same, and the U.S. Committee will notify the State and County Departments. If the Committee does not agree, a copy of the minutes and the form will be sent to the Colorado Medical Society Utilization Review Committee for review and evaluation. The results of that review will be communicated to the physician, the State Department of Health Care Policy and Financing~~Human Services~~, the County Department of Social Services, and to the U.R. Committee.

It shall be the responsibility of the Department to make the final decision, in all such cases, following a review of the recommendations of the Colorado Medical Society Utilization Review Committee, the facility Utilization Review Committee, and the attending physician.

8.461 Repealed, effective May 30, 2006

8.470 HOSPITAL BACK UP LEVEL OF CARE

8.470.1 DEFINITION

The Hospital Back Up (HBU) Program is a ~~long term~~long-term care program that provides hospital level care in a skilled nursing facility (SNF) setting. Clients who no longer need acute care in a hospital but require 24-hour monitoring and life sustaining technology for complex medical conditions may apply to receive ~~long term~~long-term care in an HBU certified facility.

8.485.50 GENERAL DEFINITIONS

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

B. Assessment shall be as defined at Section 8.390.1.B.

C. Case Mmanagement shall be as defined at Section 8.390.1.C, including the calculation of client payment and the determination of individual cost-effectiveness.

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

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

F. Uncertified Congregate Facility shall be a facility as defined at Section 8.485.50.E. that is not certified as an Alternative Care Facility. See Section 8.495.1.

G. Continued Sstay Rreview shall be a Rre-assessment as defined at Sections 8.402.60 and 8.390.1.RS.

H. Corrective Aaction Pplan shall be as defined at Section 8.390.1.D.

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

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

K. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized.

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

M. Intake/Sscreening/Rreferral shall be as defined Section 8.390.1.M.

N. Level of care screen shall be as defined as an assessment conducted in accordance with Section 8.401.

O. Provider agency shall be defined as an agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at Section 8.485.40. A Ssingle Eentry Ppoint Aagency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria in Sections 8.390-8.393 are met.

P. Reassessment shall be as defined at Section 8.390.1.RS.

Q. Service Plan means the written document that identifies approved services, including Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a client to remain safely in the community and developed in accordance with the Department rules, including the funding source, frequency, amount and provider of each service, and written on a State-prescribed Long TermLong-term Care Plan form.

R. Single Eentry point Point Aagency shall be defined as an organization described at Section 8.390.1.UV.

S. The Department shall be defined as the state agency designated as the single state Medicaid agency for Colorado.described in 8.390.1.F.

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

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

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

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

8.485.60 ELIGIBLE PERSONS

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

A. Financial Eligibility

Clients shall meet the eligibility criteria as stated at Section 8.100. Clients must also meet criteria specified in the Colorado Department of Human Services Income Maintenance Staff Manual, 9 CCR 2503-1, (2018).

B. Level of Care and Target Group

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

1. Determined by the Single Entry Point Aagency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult; and

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

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

4. A length of stay shall be assigned by the Single Entry Point Aagency for approved admissions, according to guidelines at Section 8.402.60.

C. Receiving HCBS-EBD Services

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

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

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

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

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD services while residing in such institutions unless the Ssingle Eentry Ppoint Aagency determines the client is eligible for EBD as described in Section 8.486.33.

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

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

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

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

E. Cost-effectiveness

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

F. Waiting List

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

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

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

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

a. Clients being deinstitutionalized from nursing facilities.

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

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

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

8.485.70 START DATE

.71 The start date of eligibility for HCBS-EBD services shall not precede the date that all of the requirements at ~~10 CCR 2505-10~~ ~~section~~Section 8.485.60~~,~~ have been met. The first date for which HCBS-EBD services can be reimbursed shall be the later of any of the following:

A. Financial: The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to ~~10 CCR 2505-10~~ ~~section~~Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care: This date is determined by the official ~~Utilization Review Contractor~~URC's stamp and the ~~Utilization Review Contractor~~URC ~~-~~-assigned start date on the ULTC 100.2 form.

C. Receiving Services: This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept services.

D. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the hospital or nursing facility.

.72 The start date for CTS may precede HCBS-EBD enrollment when a client meets the conditions set forth at ~~10 CCR 2505-10~~ ~~section~~Section 8.486.33. The start date for CTS shall be no more than 180 calendar days before a client's discharge from a nursing facility.

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

.91 The Department or its agent shall develop the Prior Authorization Request (PAR) form in compliance with all applicable regulations, and determine whether services requested are (a) consistent with the client's documented medical condition, and functional capacity, (b) reasonable in amount, frequency and duration, (c) not duplicative, (d) not services for which the client is receiving funds to purchase, and (e) do not total more than twenty four (24) hours per day of care.

A. The case manager shall submit prior authorization approvals for all HCBS-EBD services to the fiscal agent within one (1) calendar month after the ~~utilization review contractor~~URC's assigned start date and approval of financial eligibility.

B. The Department or its fiscal agent will approve, deny or return for additional information home modification PARs over $1,000 within ten (10) working days of receipt.

.92 When home modifications are denied, in whole or in part, the S~~s~~ingle E~~e~~ntry P~~p~~oint A~~a~~gency shall notify the client or the client's designated representative of the adverse action and their

appeal rights on a state-prescribed form, according to ~~10 CCR 2505-10~~ ~~section~~Section 8.057, et. seq.

.93 Revisions requested by providers six months or more after the end date shall always be disapproved.

.94 Approval of the PAR by the Department or its agent shall authorize providers of services under the Service Plan to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for ~~long term~~long-term care medical assistance (Medicaid) on the dates of service; and upon provider's use of correct billing procedures.

.95 Every PAR shall be supported by information on the Service Plan, the ULTC-100.2 and written documentation from the income maintenance technician of the client's current monthly income. All units of service requested on the PAR shall be listed on the Service Plan.

.96 If a PAR is for an Alternative Care Facility client who is 300% eligible, all medical and remedial care requested as deductions shall be listed on the Client Payment form.

.97 The start date on the Prior Authorization Request form shall not precede the start date of eligibility for HCBS-EBD services, according to ~~10 CCR 2505-10~~ ~~section~~Section 8.485.70, except for CTS. A TCA may provide CTS up to 180 days prior to nursing facility discharge when authorized by the Ss~~s~~ingle Ee~~e~~ntry Pp~~p~~oint Aa~~a~~gency. The TCA is eligible for reimbursement beginning on the first day of the client's HCBS-EBD enrollment.

.98 The PAR shall not cover a period ~~of time~~ longer than the length of stay assigned by the ~~Utilization Review Contractor~~URC.

Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.

8.486.20 INTAKE

.21 Refer to ~~10 CCR 2505-10~~ ~~section~~Section 8.393.~~21~~ 2.B for single entry point intake procedures. The i~~I~~ntake form shall be completed before an assessment is initiated. The i~~I~~ntake form may also be used as a preliminary case plan form when signed by the applicant, for purposes of establishing a start date.

.22 Based upon information gathered on the i~~I~~ntake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform ~~long term~~long-term care client assessment (ULTC-100), and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request an assessment if the client disagrees with the case manager's decision.

8.486.30 ASSESSMENT

.31 If the client is being discharged from a hospital or other institutional setting, the discharge planner shall contact the URC/SEP agency for assessment by emailing or faxing the i~~I~~nitial i~~I~~ntake and s~~S~~creening form ~~as required at 10 CCR 2505-10 section 8.393.21.~~.

.32 The URC/SEP case manager shall view and document the current Personal Care Boarding Home license, if the client lives, or plans to live, in a congregate facility as defined at ~~10 CCR 2505-10~~ ~~section~~Section 8.485.50, in order to ensure compliance with ~~10 CCR 2505-10~~ ~~section~~Section 8.485.20.

.33 A SEP may determine that a client is eligible for HCBS-EBD while the client resides in a nursing facility when the client meets the eligibility criteria as established at ~~10 CCR 2505-10 section~~Section 8.400, *et seq.*, the client requests CTS and the SEP includes CTS in the client's ~~long term~~long-term care plan. If the client has been evaluated with the ULTC 100.2 and has been assigned a length of stay that has not lapsed, the SEP shall not conduct another review when CTS is requested.

8.486.40 HCBS-EBD DENIALS

.41 If a client is determined, at any point in the assessment process, to be ineligible for HCBS-EBD according to any of the requirements at ~~10 CCR 2505-10 section~~Section 8.485.60, the client or the client's designated representative shall be notified of the denial and the client's appeal rights in accordance with ~~Long Term~~Long-term Care Single Entry Point System regulations at ~~10 CCR 2505-10 section~~Section 8.393.3.A.~~28.~~

8.486.80 COST CONTAINMENT

.81 The case manager shall determine whether the individual meets the cost containment criteria of ~~10 CCR 2505-10 section~~Section 8.485.50.J by using a State-prescribed PAR form to:

A. Determine the maximum authorized costs for all waiver services and ~~long term~~long-term home health services for the period of time covered by the care plan and compute the average cost per day by dividing by the number of days in the care plan period; and

B. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:

1. Enter (in the designated space on the PAR form) the monthly cost of institutional care for the individual; and

2. Subtract from that amount the individual's gross monthly income; and

3. Subtract from that amount the individual's monthly Home Care Allowance authorized amount, if any, and

4. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount.

C. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.

Sections 8.486.90 - 8.486.98 deleted by the Medical Services Board February 9, 2001.

8.486.100 REVISIONS

.101 SERVICES ADDED TO THE CARE PLAN

A. Whenever a change in the care plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the fiscal agent.

1. The revised care plan form shall list the services being revised and shall state the reason for the revision. Services on the revised care plan form, plus all services

on the original care plan form, must br e entered on the revised Prior Authorization Request form, for purposes of reimbursement.

2. The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.

B. If a revised PAR includes a new request for home modification service above the Department prescribed amount, the revised PAR shall also include all documentation listed at 10 CCR 2505-10 sectionSection 8.493.

.102 DECREASE OF SERVICES ON THE CARE PLAN

A. A revised PAR does not need to be submitted if services on the care plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.

B. If services are decreased without the client's agreement, the case manager shall notify the client of the adverse action and of appeal rights, according to Long TermLong-term Care Single Entry Point System regulations at 10 CCR 2505-10 sectionSection 8.393.28.3.A.

8.486.300 TERMINATION

.301 In accordance with Long TermLong-term Care Single Entry Point System regulations at 10 CCR 2505-10 sectionSection 8.393.28, clients shall be terminated from any SEP-managed waiver whenever they no longer meet one or more of the eligibility requirements at 10 CCR 2505-10 sectionSection 8.485.60. Clients shall also be terminated from the waiver if they die, move out of state or voluntarily withdraw from the waiver.

8.486.400 COMMUNICATION

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

A. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

B. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent, the case manager shall provide copies to all the HCBS-EBD providers in the care plan.

C. Within five (5) working days of receipt from the Utilization Review ContractorURC of the certified ULTC 100.2 form, the case manager shall send a copy of the ULTC 100.2 form to all personal care, and adult day services provider agencies on the care plan and to alternative care facilities listed on the care plan.

D. The case manager shall notify the Utilization Review ContractorURC, on a form prescribed by the Department, within thirty (30) calendar days, of the outcome of all non-diversions, as defined at 10 CCR 2505-10 sectionSection 8.485.50.

8.486.500 CASE RECORDING/DOCUMENTATION

.501 Case management documentation shall meet all of the standards found at ~~10 CCR 2505-10 section~~Sections 8,393.2.H. ~~8.393.16 and 8.393.26.~~

8.487 HCBS WAIVER PROVIDER AGENCIES

8.487.10 GENERAL CERTIFICATION STANDARDS

.11 Provider agencies shall:

A. Conform to all State established standards for the specific services they provide under this program; and

B. Abide by all the terms of their provider agreement with the Department; and

C. Comply with all federal and state statutory requirements. A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

.12 Provider agencies shall have written policies and procedures for recruiting, selecting, retaining and terminating employees.

.13 Provider agencies shall have written policies governing access to duplication and dissemination of information from the client's records in accordance with C.R.S. ~~section~~Section 26-1-114, as amended. Provider agencies shall have written policies and procedures for providing employees with client information needed to provide the services assigned, within the agency policies for protection of confidentiality.

.14 Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department of Health Care Policy and Financing~~,~~ and shall have written policies and procedures regarding emergency procedures.

.15 Provider agencies shall have written policies and procedures regarding the handling and reporting of ~~critical incident~~Critical Incidents, including accidents, suspicion of abuse, neglect or exploitation, and criminal activity. Provider agencies shall maintain a log of all complaints and ~~critical incident~~Critical Incidents, which shall include documentation of the resolution of the problem.

.16 Provider agencies shall maintain records on each client. The specific record for each client shall include at least the following information:

A. Name, address, phone number and other identifying information about the client; and

B. Name, address and phone number of the case manager and ~~single entry point agency~~Single Entry Point Agency; and

C. Name, address and phone number of the client's physician; and

D. Special health needs or conditions of the recipient; and

E. Documentation of the services provided, including where, when, to -whom and by whom the service was provided, and the exact nature of the specific tasks performed, as well as the amount or units of service. Records shall include date, month and year of service, and when applicable, the beginning and the ending time of day; and

F. Documentation of any changes in the client's condition or needs, as well as documentation of appropriate reporting and action taken as a result; and

G. For personal care agencies, documentation concerning advance directives shall be present in the client record; and

H. Documentation of supervision of care; and

I. All information regarding a client shall be kept together for easy access and review by supervisors, program monitors and auditors.

.17 Provider agencies shall maintain a personnel record for each employee. The employee record shall contain at least the following:

A. Documentation of employee qualifications.

B. Documentation of training.

C. Documentation of supervision and performance evaluation.

D. Documentation that the employee was informed of all policies and procedures required by these rules.

E. A copy of the employee's job description.

.18 A provider agency may become separately certified to provide more than one type of HCBS-EBD service if all requirements are met for certification. Administration of the different services provided shall be clearly separate for auditing purposes. The provider agency shall also understand and be able to articulate its different functions and roles as a provider of each service, as well as all the rules that separately govern each of the types of services, in order to avoid confusion on the part of clients and others.

.19 Provider agencies shall send billing and other staff to the provider billing training offered by the fiscal agent, at least once each year.

8.493.4 CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.493.4.A. The Case Manager shall consider alternative funding sources to complete the Home Modification, including, but not restricted to those sources identified and recommended by the Department and DOH on the Department website. These alternatives and the reason they are not available shall be documented in the case record.

1. The Case Manager must confirm that the client is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by the Fair Housing Act.

8.493.4.B. The Case Manager may approve Home Modification projects estimated at less than $2,500 without prior authorization, contingent on client authorization and confirmation of Home Modification fund availability.

8.493.4.C. The Case Manager shall obtain prior approval by submitting a Prior Authorization request form (PAR) to the Department for Home Modification projects estimated at between $2,500 and $14,000.

1. The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures. Home Modifications submitted with improper documentation are not authorized.

2. The Case Manager and CMA are responsible for retaining and tracking all documentation related to a client's home modification lifetime cap use and communicating that information to the client and providers. The Case Manager may request confirmation of a client's home modification lifetime cap use from the Department, its fiscal agent, or DOH.

8.493.4.D. Home Modifications estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1. An occupational or physical therapist (OT/PT) shall assess the client's needs and the therapeutic value of the requested Home Modification. When an OT/PT with experience in Home Modification is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Modification would contribute to a client's ability to remain in or return to his/her home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

2. The evaluation services may be provided by a home health agency or other qualified and approved OT/PT through Medicaid Home Health consistent with Home Health rules set forth in ~~10 CCR 2505-10~~ Section 8.520, including physician orders and plans of care.

   a. A Case Manager may initiate the OT/PT evaluation process before the client has been approved for waiver services, as long as the client is Medicaid eligible.

   b. A Case Manager may initiate the OT/PT evaluation process before the client physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

3. The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the client's needs. The Case Manager shall document these alternatives in the client's case file.

8.493.4.E. The Case Manager shall solicit bids according to the following procedures:

1. The Case Manager shall solicit bids from at least two Home Modification Providers.

   a. The Case Manager must verify that the provider is an enrolled Home Modification Provider.

   b. The bids must be submitted according to Department prescribed processes and procedures as found on the Department website.

2. The bids shall include a breakdown of the costs of the project including:

   a. Description of the work to be completed.

   b. Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.

   c. Estimate for building permits, if needed.

d. Estimated timeline for completing the project.

e. Name, address and telephone number of the Home Modification Provider.

f. Signature, including option for digital signature, of the Home Modification Provider.

g. Signature, including option for digital signature, of the client or other indication of approval.

h. Signature, including option for digital signature, of the home-owner or property manager if applicable.

3. Home Modification Providers have a maximum of thirty (30) days to submit a bid for the Home Modification project after the Case Manager has solicited the bid.

a. If the Case Manager has made three attempts to obtain a written bid from a Home Modification Provider and the Home Modification Provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

5. The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements of Section 8.493 and the recommendations of the OT/PT evaluation.

a. If a client or home-owner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

6. A revised PAR and Change Order request shall be submitted according to the procedures outlined in this sSection for any changes from the original approved PAR according to Department prescribed processes and procedures.

8.493.4.F. If a property to be modified is not owned by the client, the Case Manager shall obtain signatures from the ~~home owner~~homeowner or property manager on the submitted bids authorizing the specific modifications described therein. Signatures may be completed using a digital signature based on preference of the individual signing the form.

1. Written consent of the home-owner or property manager, as evidenced by the ~~above mentioned~~above-mentioned signatures, is required for all projects that involve permanent installation within the client's residence or installation or modification of any equipment in a common or exterior area.

2. If the client vacates the property, these signatures evidence that the home-owner or property manager agrees to allow the client to leave the modification in place or remove the modification as the client chooses. If the client chooses to remove the modification, the property must be left equivalent or better to its pre-modified condition. The ~~home owner~~homeowner or property manager may not hold any party responsible for removing all or part of a home modification project.

8.493.4.G. If the CMA does not comply with the process described above resulting in increased cost for a home modification, the Department may hold the CMA financially liable for the increased cost.

8.493.4.H. The Department or its agent may conduct on-site visits, or any other investigations deemed necessary prior to approving or denying the Home Modification request.

8.495 ALTERNATIVE CARE FACILITIES

8.495.1 DEFINITIONS

Alternative Care Facility (ACF) authorized in 25.5-6-303(3), C.R.S., means an Assisted Living Residence as defined at 6 CCR 1011-1, Chapter VII, Section 2, which has been licensed by the Colorado Department of Public Health and Environment (CDPHE) and has been certified by the Department to provide Alternative Care Services and Protective Oversight to Medicaid participants.

Alternative Care Services as described in 25.5-6-303(4), C.R.S., means, but is not limited to, a package of personal care and homemaker services provided in a state licensed and certified alternative care facility including: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding, ambulation, transfers, positioning, bladder & bowel care, medication reminding and monitoring, accompanying, routine housecleaning, meal preparation, bed making, laundry, and shopping. Alternative Care Services also includes Medication Administration.

Care Plan means the individualized goal-oriented plan of services, supports, and preferences developed collaboratively with the participant and/or the designated or legal representative and the service provider, as outlined in 6 CCR 1011-1, Chapter VII, Section 2 and ~~10 CCR 2505-10~~, Section 8.495.6.F.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 6 CCR 1011-1, Chapter VII, Section 7.9 and 6 CCR 1011-1, Chapter VII, Section 7.16.

Medication Administration as described in 25-1.5-301, C.R.S., means assisting a participant with taking medications while using standard healthcare precautions, according to the legibly written or printed order of an attending physician or other authorized practitioner. Medication administration may include assistance with ingestion, application, inhalation, and rectal or vaginal insertion of medication, including prescription drugs. Provider must document and keep record of each medication administered, including the time and the amount taken. “Administration” does not include judgment, evaluation, assessment, or the injections of medication, the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by the participant.

Non-Medical Leave Days mean days of leave from the ACF by the participant for non-medical reasons such as family visits.

Programmatic Leave Days mean days of leave from the ACF prescribed for a participant by a physician for therapeutic and/or rehabilitative purposes.

Protective Oversight means care and service as defined at 6 CCR 1011-1, Chapter VII, Section 2 and ~~10 CCR 2505-10~~, Section 8.489.31.S., which includes the monitoring and guidance of a participant to assure their health, safety, and well-being, and a general awareness of a participant’s whereabouts. Protective oversight also includes~~,~~ but is not limited to: monitoring the participant while on the premises, monitoring the participant’s needs, and ensuring that the participant receives the services and care necessary to protect the participant’s health and welfare.

Provider means the entity that holds the Assisted Living Residence/Facility license and certification and shall be responsible or delegate responsibility to appropriate staff for the delivery of Alternative Care Services.

Resident Agreement means a written agreement specifying at a minimum the services to be provided, charges and refund policies, written disclosures of information, discharge procedures, and management of participant funds/property, which shall be signed by the participant and/or participant's guardian or other legal representative as outlined in 6 CCR 1011-1, Chapter VII, Section 11.3-6.

Secured Environment means an ACF that operates as defined in 6 CCR 1011-1, Chapter VII Section 2.

8.495.2 PARTICIPANT ELIGIBILITY

A. Participants in the Home and Community Based Services (HCBS) Elderly, Blind and Disabled waiver pursuant to ~~10 CCR 2505-10~~, Section 8.485 and the HCBS Community Mental Health Supports waiver pursuant to ~~10 CCR 2505-10~~, Section 8.509 are eligible to receive services in an Alternative Care Facility.

B. Potential participants shall be assessed, at a minimum, by a team that includes the participant and/or guardian or other legal representative, the ACF administrator or appointed representative, and Case Management Agency (CMA) case manager. If one of the parties listed above is not available, input or information must be obtained from each party prior to making an admission determination. It may also include family members, Accountable Care Collaborative or Mental Health Center case managers, and any other interested parties as approved by the participant, to determine that the ACF is an appropriate community setting that will meet the individual's choice and need for independence and community integration.

1. An assessment will be conducted prior to admission, annually, and whenever there is a significant change in physical, cognitive, or behavioral needs, or as requested by the participant. The annual assessment must be completed by the team outlined in ~~10 CCR 2505-10~~, Sections 8.495.2.B.

2. The assessment will document that the facility is able to support the participant and their needs. The assessment will also document the participant's physical, behavioral and social needs, so that supports can be identified to enable them to lead as independent a life as possible. The assessment will be used to develop the participant's Care Plan.

8.495.3 PARTICIPANT BENEFITS

A. Alternative Care Services which include, but are not limited to, personal care and homemaker services pursuant to ~~10 CCR 2505-10~~, Sections 8.489 and 8.490, are benefits to participants residing in an ACF.

1. Medication Administration is included in the reimbursement rate for Alternative Care Services and shall not be additionally reimbursed or billed in any other manner.

B. Room and board shall not be a benefit of Alternative Care Services. Participants shall be responsible for room and board in an amount not to exceed the Department's established rate.

C. Participant engagement opportunities shall be provided by the ACF, as outlined in 6 CCR 1011-1, Chapter VII, Section 12.19-26.

8.495.4 PARTICIPANT RIGHTS

A. An ACF must be integrated in the community and foster the independence of the participant while promoting each participant's individuality, choice of care, and lifestyle.

1. The participant's choice to live in an ACF shall afford the participant the opportunity to responsibly contribute to the home in meaningful ways and shall avoid reducing personal

choice and initiative. The participant's individual behaviors shall not negatively impact the harmony of the ACF.

B. The facility must ensure that a lease, residency agreement, or other form of a written agreement will be in place for each HCBS participant and provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

1. A violation of a lease or resident agreement that leads to a discharge must include at least 30 days' notice to the participant and/or their guardian or other legal representative, and a copy of the written notice shall be sent to the state or local ombudsman within five calendar days of the date that it was provided to the participant.

C. Participants shall be informed of their rights, according to 6 CCR 1011-1, Chapter VII, Section 13. Pursuant to 6 CCR 1011-1, Chapter VII, Section 13.1, the policy on resident rights shall be in a visible location so that they are always available to participants and visitors.

1. These rights include but are not limited to:

a. Participants have the choice in selecting the ACF in which they reside;

b. Participants are afforded the right and opportunity to responsibly contribute to the home in meaningful ways, engage in community life, and express personal choice;

c. Participants have the right to dignity and privacy, including in their living/sleeping units;

d. Participants shall have choice in a roommate, with the provider accommodating roommate choices. If the facility only has one bed in a two-bed room available, the new individual and the current occupant must at least have a chance to meet and determine whether they are willing to share a room; and

e. Communication with staff that is respectful and in a dignified manner.

2. The following rights may be modified when supported by a specific and assessed need, as determined by the provider, participant, and case manager:

a. Participants have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment;

b. Participants shall have access to food at all times, choose when and what to eat, and shall have access to food preparation areas if they can appropriately handle kitchen equipment as documented in the Care Plan;

c. Participants and their roommates shall have personal quarters with entrance doors lockable by the individual and shall control access to their quarters, unless otherwise specified in their Care Plan. Only appropriate staff shall have keys to private quarter doors, as specified in the Care Plan;

d. Participants shall have the freedom and support to determine their own schedules and activities, including methods of accessing the greater community;

e. Participants shall have the right to possess and self-administer medications with a physician's written order and approval of the self-administration of medications,

(along with a copy of the physician's written order supporting self-administration) which shall be documented in the Care Plan;

f. The right to have visitors at any time;

g. The right to control his/her personal resources;

h. The right to have access to the entire facility; and

i. The right to receive unopened mail.

3. The Care Plan must include proper documentation supporting the modification, which includes but is not limited to:

a. Identification of a specific and individualized assessed need;

b. Documentation of the positive interventions and less intrusive methods that have been used to support the well-being and needs of the participant;

c. Informed consent of the participant or their guardian/other legal representative;

d. Documentation of the participant's case manager involvement of any rights modification; and

e. Modifications to the Care Plan and supporting documentation must be reviewed, at a minimum, on an annual basis.

D. Participants shall be informed of all ACF policies upon admission to the facility, and when changes to policies are made, rules and/or policies shall apply consistently to the administrator, staff, volunteers, and participants residing in the facility and their family or friends who visit. Participant acknowledgement of rules and policies must be documented in the Care Plan or a participant agreement.

E. Participants shall be informed of the facility's policies and procedures for implementation of an individual's advance directives, should the need arise.

F. If requested by the participant, the ACF shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal possessions.

G. Providers shall not require a Medicaid participant to take part in performing household or other related tasks.

8.495.5 PROVIDER ELIGIBILITY

A. The Provider shall be licensed in accordance with 6 CCR 1011-1, Chapters II and VII.

B. Certification Standards

1. The Provider shall be Medicaid certified by the Department as an ACF in accordance with 10 CCR, 2505-10, Section 8.487.20.

2. Certification shall be denied, revoked, terminated or suspended when a Provider is unable to meet, or adequately correct deficiencies relating to, licensure and/or

certification standards as defined at 6 CCR 1011-1, Chapter VII and ~~10 CCR 2505-10~~, Section 8.495.

3. ACF Providers shall maintain a copy of any license, ACF certification, proof of insurance or bond, W-9, and any other documentation as required by state or local authority. Providers shall submit to the Department a copy of the assisted living residence license upon renewal or change of ownership.

4. Administrators shall be qualified as defined at 6 CCR 1011-1, Chapter VII, Section 6, prior to Medicaid certification.

C. The Provider shall enter into a Provider Agreement with the Department upon the completion of the provider application and ACF certification.

D. The Provider Agreement shall be denied, revoked, suspended, or terminated if an ACF provider does not operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation, and other standards prescribed in law or regulations.

E. Notification to the Department of Significant ACF Change

1. Suspension, Revocation or Termination

a. ACF Providers shall notify the Department within five working days when any required license, certification, insurance or bond has a change in status, including any suspension, revocation or termination.

2. Change of Ownership

a. Providers shall provide written notice to the Department of intent to change ownership no later than 30 days before the sale of the facility.

i. The new owner shall not automatically become a Medicaid provider without meeting licensing, certification, and approval process standards.

8.495.6 PROVIDER ROLES AND RESPONSIBILITIES

A. All documentation, including but not limited to, individual resident agreements and Care Plans, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to ~~10 CCR 2505-10~~, Section 8.130 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request.

B. Participant Engagement

1. Providers shall, in consultation with the participants, provide social and recreational engagement opportunities both within and outside the facility.

a. Opportunities for social and recreational engagement shall take into consideration the individual interests and wishes of the participants.

b. In determining the types of opportunities and activities offered, the provider shall consider the physical, social, and mental stimulation needs of the participants.

C. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:

   a. Death;

   b. Abuse/neglect/exploitation;

   c. Injury to participant or illness of participant;

   c. Damage or theft of participant's property;

   d. Medication mismanagement;

   e. lost or missing person; ~~and~~

   f. criminal activity;~~,~~ and

   g. A harmful act committed against the participant by a person with a relationship to the participant when such act is not defined as abuse, caretaker neglect, or exploitation but causes harm to the health, safety, or welfare of a participant.

2. A provider must submit a written or verbal report of a Critical Incident to the participant's case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

   a. Participant name;

   b. Participant identification number;

   c. Waiver;

   d. Incident type;

      i. Mistreatment, Abuse, Neglect or Exploitation (MANE)

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

   e. Date and time of incident;

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

   g. Persons involved;

   h. Description of incident; and

   i. Resolution, if applicable.

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

3. If any of the above information is not available within 24 hours of incident and not reported to the case manager, a follow-up to the initial report must be completed. Failure to report incidents may result in corrective action by the Department.

D. Participant Leave

1. Providers shall notify the participant's case manager of any participant planned or unplanned non-medical and/or programmatic leave for greater than 24 hours.

2. The therapeutic and/or rehabilitative purpose of leave shall be documented in the participant's Care Plan.

E. Additional Charges

1. Any additional monies assessed to the participant or their family and/or guardian:

a. Shall not be for Medicaid services;

b. Shall be clearly delineated in the resident agreement; and

c. Shall be fully refunded except for withholdings which are in accordance with the resident agreement and are clearly defined on the day of discharge.

F. Care Plan

1. The following information must be documented in the Care Plan:

a. Medical Information:

i. If the participant is taking any medications and how they are administered, with reference to the Medication Administration Record (MAR);

ii. Special dietary needs, if any; and

iii. Reference to any documented physician orders.

b. Social and recreational engagement:

i. The participant's preferences and current relationships; and

ii. Any restrictions on social and/or recreational activities identified by a physician.

c. Any other special health or behavioral management needs that supports the participant's individual needs.

d. Additional Care Planning Documentation:

i. Documentation from the admission process which demonstrates that the facility was selected by the participant;

ii. Identification of the Individual's goals, choices, preferences, and needs and incorporation of these elements into the supports and services outlined in the Care Plan;

iii. Any modifications to the participants rights, with the required supporting documentation; and

iv. Evidence the participant and/or their guardian, designated representative, or legal representative has had the opportunity to participate in the development of the Care Plan, has reviewed it, and has signed in agreement with the plan.

G. Environmental Standards

1. The Alternative Care Facility is an environment that supports individual comfort, independence and preference, maintains a home-like quality and feel for participants at all times, and provides participants with unrestricted access to the facility in accordance with the residency agreement or modifications as agreed to and documented in the participant's Care Plan.

2. Facilities shall provide an outdoor area accessible to participants without staff assistance that is well maintained, facilitates community gatherings, and is appropriately equipped for the population served.

3. Facilities shall provide access for participants to make private phone calls at their preference and convenience.

4. Facilities shall provide comfortable places for private visits with family, friends and other visitors.

5. Facilities shall provide easily accessible common areas and a physical environment that meets the needs of any participant needing support.

6. Facilities shall maintain a comfortable temperature throughout the facility and participant rooms, sufficient to accommodate the use and needs of the participants, never to exceed 80 degrees.

7. The facility shall develop and follow written policies and procedures to ensure the continuation of necessary care to all residents for at least 72 hours immediately following any emergency including, but not limited to, a long-term power failure.

8. The monthly schedule of daily recreational and social engagement opportunities shall be in a visible location so that they are always available to participants and visitors, and developed in accordance with 6 CCR 1011-1, Chapter VII, Section 12.26, pertaining to Resident Engagement.

   a. Staff shall be responsible for ensuring that the daily schedule of recreational and social engagement opportunities is implemented and offered to all participants.

9. Reading material shall be available in the common areas at all times, reflecting the interests, hobbies, and requests of the participants.

10. Facilities shall provide nutritious food and beverages that participants have access to at all times. Access to food and cooking of food shall be in accordance with 6 CCR 1011-1, Chapter VII, Section 17.1-3~~.~~. The access to food shall be provided in at least one of the following ways:

    a. Access to the ACF kitchen.

b. Access to an area separate from the ACF kitchen stocked with nutritious food and beverages.

c. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the participant's bedroom.

d. A safe, sanitary way to store food in the participant's room.

11. Each participant's cooking capacity shall be assessed as part of the pre-admission process and updated in the Care Plan as necessary.

H. Provider Service Requirements

1. The facility shall provide Protective Oversight and Alternative Care services to participants every day of the year, 24 hours per day.

2. Alternative Care Facility Providers shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 CCR 1011-1, Chapter VII and XXIV, Medication Administration Regulations.

3. Providers shall not discontinue services to a participant unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services.

4. The facility shall develop emergency policies that address, at a minimum, a plan that ensures the availability of, or access to, emergency power for essential functions and all resident-required medical devices or auxiliary aids.

5. Providers shall have written policies and procedures for employment practices.

6. Providers shall maintain the following records/files:

a. Personnel files for all staff and volunteers shall include:

i. Name, home address, phone number and date of hire.

ii. The job description, chain of supervision and performance evaluation(s).

b. It shall be the responsibility of the Administrator to establish written policies concerning employee health, as outlined in 6 CCR 1011-1, Chapter VII, Section 7.6.

c. Participant files shall be kept confidential and shall include:

i. The participant's assessment outlined in ~~10 CCR 2505-10~~, Sections 8.495.2. B. and Care Plan per 8.495.6.F.

7. The facility shall encourage and assist participants' participation in engagement opportunities and activities within the ACF community and the wider community, when appropriate.

I. Staffing Requirements

1. Each facility will divide the 24-hour day into two 12-hour blocks which will be considered daytime and nighttime. The designation of daytime and nighttime hours shall be permanently documented in facility policy and disclosed in the written resident

agreements. In determining appropriate staffing levels, the facility shall adjust staffing ratios based on the individual acuity and needs of the participants in the facility. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition Direct Care Staff defined at ~~10 CCR 2505-10~~, Sections 8.495.1. Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

2. Staffing at a facility shall be no less than the following standards:

   a. A minimum of 1 staff to 10 participants during the daytime.

   b. A minimum of 1 staff to 16 participants during the nighttime.

   c. A minimum of 1 staff to 6 participants in a Secured Environment at all times.

      i. There shall be a minimum of one awake staff member that is on duty during all hours of operation in a Secured Environment.

3. Staffing Ratio Waiver

   a. Staffing waiver requests shall be submitted to the Department's ACF Benefit Administrator. They will be evaluated and granted based on several criteria. This includes, but is not limited to:

      i. Years facility has been in operation;

      ii. Past ~~critical incident~~Critical Incidents at the facility;

      iii. The Provider has adequately documented how a staffing waiver would not jeopardize the health, safety or quality of life of the participants;

      iv. Provider availability and client access; and

      v. Free of deficiencies impacting participant health and safety in both the CDPHE and Life Safety Code survey and inspections.

   b. An approved staffing waiver is only applicable for nighttime hours, with the exception for Secured Environments.

   c. A staffing waiver expires five years from the date of approval. Continuance of staffing waiver requires Department approval.

   d. Any existing staffing waiver may be subject to revocation if a facility does not comply with any applicable regulations, is cited with deficiencies impacting participant health and safety by CDPHE or the Division of Fire Protection Control, has substantiated patient care complaints, or the staffing waiver has jeopardized the health, safety or quality of life of the participants.

      i. In the event of a staffing waiver denial or revocation, a facility may reapply for a staffing waiver only after the facility receives a CDPHE and Life Safety survey with no deficiencies impacting participant health and safety

ii. Existing staffing waivers shall be null and void upon a change in the total number of licensed beds or a change of ownership in a facility.

4. The facility shall ensure that all staff and volunteer training be completed within the first 30 days of employment. Training shall include, but is not limited to, the training topics outlined in 6 CCR 1011-1, Chapter VII, Section 7.9.

5. The Provider shall ensure the Administrator and all staff meet the qualifications and employment standards set forth in 6 CCR 1011-1, Chapter VII, Section 7.4-7.

J. Standards for Secured Environment ACFs

1. Facilities providing a secured environment may be licensed for a maximum of 30 secured beds.

a. A waiver may be granted by the Department when adequate documentation of the need for additional beds has been proven and the number of beds would not jeopardize the health, safety and quality of care of participants.

2. The facilities shall establish an environment that promotes independence and minimizes agitation and unsafe wandering through the use of visual cues and signs.

3. Provide a secured outdoor area accessible without staff assistance, which shall be level, well maintained, and appropriately equipped for the population served.

K. Appropriateness of Medicaid Participant Placement

1. An ACF shall not admit, or shall discharge within 30 days, any participant, who:

a. Needs skilled services on more than an intermittent basis. Skilled services shall only be provided on an intermittent basis by a Medicaid certified home health provider.

b. Is diagnosed with a substance abuse issue and refuses treatment by the appropriate mental health and/or medical professionals, and cannot be safely served by the facility.

c. Has an acute physical illness which cannot be managed through medications or prescribed therapy.

e. Exhibits behavior that:

i. Disrupts the safety, health and social needs of the home.

ii. Poses a physical threat to self or others, including but not limited to, violent and disruptive behavior and/or any behavior which involves physical, sexual, or psychological force or intimidation and fails to respond to interventions, as outlined in the participant's Care Plan.

iii. Demonstrates an unwillingness or inability to maintain appropriate personal hygiene under supervision or with assistance.

iv. Is consistently disorientated to time, person and place to such a degree they pose a danger to self or others and the ACF does not provide a Secured Environment.

h. Has physical limitations that:

i. Limit ambulation, unless compensated for by assistive device(s) or with assistance from staff.

2. All discharges, including emergency discharges, shall be in accordance to 6 CCR 1011-1, Chapter VII, Section 11.11.

3. Participants admitted for Respite Care to the ACF must meet the same criteria as other participants for appropriate placement.

8.500 HOME AND COMMUNITY-BASED SERVICES FOR ~~THE~~ INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL~~LY~~ DISABL ITIES~~ED~~ (HCBS-DD) WAIVER

8.500.1 This Section hereby incorporates the terms and provisions of the federally-approved Home and Community-based Services for ~~Persons~~Individuals with Intellectual or Developmental~~ly~~ Disabilities (HCBS-DD) waiver ~~(HCBS-DD) CO.0007.R06.00~~. To the extent that the terms of that federally-approved waiver are inconsistent with the provisions of this Section, the waiver will control.

8.500.1 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD waiver or a HCBS waiver service.

C. APPLICANT means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. AUDITABLE means the information represented on the wavier cost report can be verified by reference to adequate documentation as required by generally accepted auditing standards.

E. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving services in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.

F. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

G. CLIENT means an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

H. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

I. COMMUNITY CENTERED BOARD means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

J. COST CONTAINMENT means limiting the cost of providing care in the community to 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 and Medicaid state plan benefits including ~~long term~~long-term home health services and targeted case management.

K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means as defined in 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and is defined as:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a Client with an intellectual ~~or developmental~~or developmental disability has been given by a court; or,

A spouse; or,

The Client's children.

Q. FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for ~~long term~~long-term services and supports as determined by the Department's prescribed instrument.

~~R.FUN~~CTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform ~~Long Term~~Long-term Care instrument and medical verification on the Professional Medical Information Page to determine if the Client meets the institutional Level of Care (LOC).

S. GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) Clients receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment as a residential care facility or residential community home for persons with developmental disabilities.

T. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem S, as set forth in Section 15-14-102 (4), C.R.S.

U. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in ~~article~~ Article 33 of T~~t~~itle 22, C.R.S.

V. HOME AND COMMUNITY-~~-~~BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IDD)

W. INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation services provided to three (3) or fewer Clients in a single residential setting or in a host home setting that does not require licensure by the Colorado Department of Public Health and Environment.

X. INSTITUTION means a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IDD) for which the Department makes Medicaid payment under the Medicaid State Plan.

Y. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately-~~-~~operated facility that provides health and habilitation services to a Client with an intellectual or developmental disability or related conditions.

Z. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.

AA. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

BB. ~~LONG TERM~~LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

CC. MEDICAID ELIGIBILE means an applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

DD. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

EE. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

FF. NATURAL SUPPORTS means non-paid informal relationships that provide assistance and occur in the Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

GG. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

HH. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent or the Case Management Agency.

II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) ~~means the medical information document signed by a licensed medical professional used as a component of the LOC evaluation to determine a Client's need for LTSS~~ means the medical information form signed by a licensed medical professional used to certify the client's medical necessity for long-term care services.

JJ. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined Section 8.600.4 *et seq.*, that has received program approval to provide HCBS-DD waiver services.

KK. PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use, including vehicles for hire.

LL. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

MM. RETROSPECTIVE REVIEW means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the support plan and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

NN. SERVICE PLAN means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.

OO. STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER means the state owned and operated agency providing HCBS waiver services to Clients enrolled in the HCBS-DD waiver.

PP. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

QQ. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

RR. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP),

HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

SS. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. That may include, but are not limited to, community resources, services provided through private insurance, non-profit services and other government programs.

TT. WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.500.2 HCBS-DD WAIVER ADMINISTRATION

8.500.2.A HCBS-DD shall be provided in accordance with the federally approved waiver document and these rules and regulations~~, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities, 2 CCR 503-1 and promulgated in accordance with the provision of § 25.5-6-404(4), C.R.S.~~.

~~8.500.2.BIn the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the provisions of § 25.5-6-404(4), C.R.S., shall apply and the regulations of the Department shall control.~~

~~8.500.2.CThe HCBS-DD Waiver is operated by the Department of Human Services, Division for Developmental Disabilities under the oversight of the Department of Health Care Policy and Financing.~~

8.500.2.~~.D~~B The HCBS-DD w~~W~~aiver provides the necessary support to meet the daily living needs of a ~~client~~Client who requires access to 24-hour support in a community-based residential setting.

8.500.2.~~E~~C HCBS-DD Waiver services are available only to address those needs identified in the functional needs assessment and authorized in the service plan and when the service or support is not available through the Medicaid state plan, EPSDT, natural supports or third-party resources.

8.500.2.~~F~~D THE HCBS-DD WAIVER:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments do not to exceed the federally approved capacity, and

4. May limit the enrollment when utilization of the HCBS-DD Waiver program is projected to exceed the spending authority.

8.500.3 GENERAL PROVISIONS

8.500.3.A The following provisions shall apply to the ~~Home and Community Based Services for persons with developmental disabilities (~~HCBS-DD~~)~~ waiver.

1. ~~Home and Community Based Services for persons with developmental disabilities (~~HCBS-DD~~)~~ waiver services shall be provided as an alternative to ~~to~~ ICF-~~MR~~ IID services for a~~n~~ C~~c~~lient with intellectual or developmental disabilities.

2. HCBS-DD is waived from the requirements of Section 1902(a)(10)(B) of the Social Security Act concerning comparability of services. The availability of some services may not be consistent throughout the State of Colorado.

3. A ~~client~~Client enrolled in the HCBS-DD w~~W~~aiver shall be eligible for all other Medicaid services for which the ~~client~~Client qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-DD w~~W~~aiver. Services received through the HCBS-DD w~~W~~aiver may not duplicate services available through the state plan.

8.500.4 CLIENT ELIGIBILITY

8.500.4.A To be eligible for the HCBS-DD w~~W~~aiver, an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability,

2. Be eighteen (18) years of age or older,

3. Require access to services and supports twenty-four (24) hours a day,

4. Meet ICF-~~MR~~IID level of care as determined by the functional needs assessment, and

5. Meet the Medicaid financial determination for LTC eligibility as specified in ~~10 CCR 2505-10,~~ Section 8.100, *et seq.*

8.500.4.B The ~~client~~Client shall maintain eligibility by meeting the criteria as set forth in ~~10 CCR 2505-10,~~ Section 8.500.6.A.1 and .2 and the following:

1. Receives at least one (1) HCBS waiver service each calendar month.

2. Is not simultaneously enrolled in any other HCBS waiver.

3. Is not residing in a hospital, nursing facility, ICF-~~MR~~IID, correctional facility or other institution.

4. Is served safely in the community with the type and amount of waiver services available and within the federally approved capacity and cost containment limits of the waiver.

5. Resides in a GRSS or IRSS setting.

8.500.4.C When the HCBS-DD Waiver reaches capacity for enrollment, a ~~client~~Client determined eligible for the waiver shall be eligible for placement on a wait list in accordance with these rules at ~~10 CCR 2505-10,~~ Section 8.500.7.

8.500.5 HCBS-DD WAIVER SERVICES

8.500.5.A SERVICES PROVIDED

1. Behavioral Services
2. Day Habilitation Services and Supports
3. Dental Services
4. Home Delivered Meals
5. Non-Medical Transportation
6. Peer Mentorship
7. Residential Habilitation Services and Supports (RHSS)
8. Specialized Medical Equipment and Supplies
9. Supported Employment
10. Transition Setup
11. Vision Services

8.500.5.B DEFINITIONS OF SERVICES

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

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

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

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

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

    d. Behavioral Services include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Day Habilitation Services and Supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the ~~client~~Client's private residence or other residential

living arrangement, except when services are necessary in the residence due to medical or safety needs.

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

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

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

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

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

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

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

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

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

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

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

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

e. Prevocational Services are provided to prepare a ~~client~~Client for paid community employment. Services consist of teaching concepts including attendance, task

completion, problem solving and safety, and are associated with performing compensated work.

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

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

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

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

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

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

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

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

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

a. Preventative services include:

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

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv). Non-intravenous sedation,

v) Basic and deep cleanings,

vi). Mouth guards,

vii) Topical fluoride treatment, and

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

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

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

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth

c. Major services include:

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

ii) Crowns

iii) Bridges

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

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

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

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

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

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

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

4. Home Delivered Meals as defined at Section 8.553.1.

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

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

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

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

6. Peer Mentorship as defined at Section 8.553.1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Specialized Medical Equipment and Supplies include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   h. Documentation of the ~~client~~Client's application for services through the Colorado Department of ~~Human Services Division of~~ Labor and Employment Vocational

Rehabilitation shall be maintained in the file of each ~~client~~Client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education CCT (20 U.S.C. Section 1400 et seq.).

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

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

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

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

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

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

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

10. Transition Setup services as defined at Section 8.553.1.

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

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

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

ii) Prior authorized in accordance with Operating Agency procedures.

8.500.6 SERVICE PLAN

8.500.6.A The Case Management Agency shall complete a Service Plan for each Client enrolled in the HCBS-DD waiver in accordance with Section 8.519.11.B.2.

8.500.6.D The Service Plan must be reported in the Department prescribed system and include the following employment information for individuals eligible for or receiving Supported Employment services, if applicable:

1. Sector and type of employment;

2. Mean wage per hour earned; and

3. Mean hours worked per week.

8.500.7 WAITING LIST PROTOCOL

8.500.7.A There shall be one waiting list for persons eligible for the HCBS-DD wWaiver when the total capacity for enrollment or the total appropriation by the general assembly has been met.

8.500.7.B The name of a person eligible for the HCBS-DD wWaiver program shall be placed on the waiting list by the community centered board making the eligibility determination.

8.500.7.C When an eligible person is placed on the waiting list for HCBS-DD wWaiver services, a written notice of action including information regarding clientClient rights and appeals shall be sent to the person or the person's legal guardian in accordance with the provisions of 10 CCR 2505-10 Section 8.057 *et seq.*

8.500.7.D The placement date used to establish a person's order on a waiting list shall be:

1. The date on which the person was initially determined to have a developmental disability by the community centered board; or

2. The fourteenth (14) birth date if a child is determined to have a developmental disability by the community centered board prior to the age of fourteen.

8.500.7.E As openings become available in the HCBS-DD Waiver program in a designated service area, that community centered board shall report that opening to the Operating Agency.

8.500.7.F Persons whose name is on the waiting list shall be considered for enrollment to the HCBS-DD wWaiver in order of placement date on the waiting list. Exceptions to this requirement shall be limited to:

1. An emergency situation where the health and safety of the person or others is endangeredendangered, and the emergency cannot be resolved in another way. Persons at risk of experiencing an emergency are defined by the following criteria:

    a. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; or whose primary residence during the night is a public or private facility that provides temporary living accommodations; or any other unstable or non-permanent situation; or is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

    b. Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in the person's present living situation and the person's health, safety or well-being is in serious jeopardy.

    c. Danger to others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure safety of the person in the community.

    d. Danger to self: a person's medical, psychiatric or behavioral challenges are such that the person is seriously injuring/harming self or is in imminent danger of doing so.

    e. Loss or Incapacitation of Primary Caregiver: a person's primary caregiver is no longer in the person's primary residence to provide care; or the primary caregiver

is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or the primary caregiver is age 65 years or older and continuing to provide care poses an imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.

8.500.7.G Enrollments may be reserved to meet statewide priorities that may include:

1. A person who is eligible for the HCBS-DD Waiver and is no longer eligible for services in the foster care system due to an age that exceeds the foster care system limits,

2. Persons who reside in ~~long term~~long-term care institutional settings who are eligible for the HCBS-DD Waiver and have a requested to be placed in a community setting, and

3. Persons who are in an emergency situation.

8.500.7.H Enrollments shall be authorized to persons based on the criteria set forth by the general assembly in appropriations when applicable.

8. 500.7.I. A person shall accept or decline the offer of enrollment within thirty (30) calendar days from the date the enrollment was offered. Reasonable effort shall be made to contact the person, family, legal guardian, or other interested party.

1. Upon a written request of the person, family, legal guardian, or other interested party an additional thirty (30) calendar days may be granted to accept or decline an enrollment offer.

2. If a person does not respond to the offer of enrollment within the allotted time, the offer is considered declined and the person will maintain their order of placement date.

8.500.8 CLIENT RESPONSIBILITIES

8.500.8.A A ~~client~~Client or guardian is responsible to:

1. Provide accurate information regarding the ~~client~~Client's ability to complete activities of daily living,

2. Assist in promoting the ~~client~~Client's independence,

3. Cooperate in the determination of financial eligibility for Medicaid,

4. Notify the case manager within thirty (30) days after:

a. Changes in the ~~client~~Client's support system, medical, physical or psychological condition or living situation including any hospitalizations, emergency room admissions, placement to a nursing home or ~~ intermediate care facility for the mentally retarded (~~ICF-~~MR~~IID~~)~~,

b. The ~~client~~Client has not received an HCBS waiver service during one (1) month,

c. Changes in the ~~client~~Client's care needs,

d. Problems with receiving HCBS w~~W~~aiver services,

e. Changes that may affect Medicaid financial eligibility including prompt reporting of changes in income or assets.

8.500.9 PROVIDER REQUIREMENTS

8.500.9.A A private or profit or not for profit agency or government agency shall meet the minimum provider qualifications as set forth in the HCBS wWaiver and shall:

1. Conform to all state established standards for the specific services they provide under HCBS-DD,

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,

4. Discontinue services to a clientClient only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services,

5. Have written policies governing access to duplication and dissemination of information from the clientClient's records in accordance with state statutes on confidentiality of information at § Section 25.5-1-116, C.R.S., as amended,

6. When applicable, maintain the required licenses from the Colorado Department of Public Health and Environment, and

7. Maintain clientClient records to substantiate claims for reimbursement according to Medicaid standards.

8. HCBS-DD providers shall comply with:

   a. All applicable provisions of Section Title 27 Article 10.5, C.R.S. et seq, and all rules and regulations as set forth in 2 CCR 503-1, Section 16 *et seq.*.

   b. All federal program reviews and financial audits of the HCBS-DD wWaiver services,

   c. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,

   d. Requests from the County Departments of Social/Human Services to access records of clientClients receiving services held by Case Management Agencies as required to determine and re-determine Medicaid eligibility

   e. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-DD wWaiver, and

   f. Requests by the Case Management Agency to monitor service delivery through targeted case management activities.

8.500.9.B Supported Employment provider training and certification requirements

1. Supported Employment service providers, including Supported Employment professionals who provide individual competitive integrated employment, as defined in 34

C.F.R. 361.5(c)(9) (2018), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and certification requirements. The incorporation of 34 C.F.R. 361.5(c)(9) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to ~~C.R.S. §~~ Section 24-4-103(12.5)~~, C.R.S., (2018),~~ the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of the incorporated material will be provided at cost upon request.

a. Subject to the availability of appropriations for reimbursement in section 8.500.14.H. Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

i. Deadlines.

1) Existing staff, employed by the Provider on or before July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

2) Newly hired staff, employed by the Provider after July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

a) Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

ii. Department approval required.

1) The Training Certificate or Certification required under section 8.500.9.B.1.a must be pre-approved by the Department.

a) Providers must submit the following information to the Department for pre-approval review:

i) Provider name.

ii) A current Internal Revenue Service Form W-9.

iii) Seeking approval for:

1) Training Certificate, or

2) Certification, or

3) Training Certificate and Certification.

iv) Name of training, if applicable, including:

1) Number of staff to be trained.

2) Documentation that the training is nationally recognized, which includes but is not limited to, standards that are

set and approved by a relevant industry group or governing body nationwide.

v) Name of Certification, if applicable, including:

1) Number of staff to receive Certification.

2) Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

vi) Dates of training, if applicable, including:

1) Whether a certificate of completion is received.

vii) Date of Certification exam, if applicable.

b) Department approval will be based on alignment with the following core competencies:

i) Core values and principles of Supported Employment, including the following:

1) The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.

ii) The Person-centered process, including the following:

1) The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-centered approach includes working with a team where the individual chooses the people involved on the team and receives: necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.

iii) Individualized career assessment and planning, including the following:

1) The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.

iv) Individualized job development, including the following:

1) Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.

v) Individualized job coaching, including the following:

1) Providing necessary workplace supports to ~~client~~Clients with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.

vi) Job Development, including the following:

1) Effectively engaging employers for the purpose of community job development for ~~client~~Clients with significant disabilities, which meets the needs of both the employer and the ~~client~~Client.

c) The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and notify the Provider of its determination within 30 days of receiving the pre-approval request under 8.500.9.B.1.a.ii.1.a.

8.500.12 PRIOR AUTHORIZATION REQUESTS

8.500.12.A Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14.

8.500.13 RETROSPECTIVE REVIEW PROCESS

8.500.13.A Services provided to a ~~client~~Client are subject to a Retrospective Review by the Department and the Operating Agency. This Retrospective Review shall ensure that services:

1. Identified in the service plan are based on the ~~client~~Client's identified needs as stated in the functional needs assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a ~~client~~Client are in accordance with the service plan, and

4. Provided within the specified HCBS service definition in the federally approved HCBS-DD w~~W~~aiver,

8.500.13.B When the retrospective review identifies areas of noncompliance, the Case Management Agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.13.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.500.13.D When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.14 PROVIDER REIMBURSEMENT

8.500.14.A Providers shall submit claims directly to the Department's Fiscal Agent through the Medicaid Management Information System (MMIS); or through a qualified billing agent enrolled with the Department's Fiscal Agent.

8.500.14.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally-approved HCBS-DD wWaiver,

2. Services have been prior authorized,

3. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the clientClient's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.14.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.14.D When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.14.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.14.F For private providers payment is based on a statewide fee schedule.

8.500.14.G Reimbursement paid to State or local government HCBS waiver providers differs from the amount paid to private providers of the same service. No public provider may receive payments in the aggregate that exceed its actual costs of providing HCBS waiver services.

1. Reimbursement paid to State and local government HCBS waiver providers shall not exceed actual costs. All State and local HCBS waiver providers must submit an annual cost report for HCBS waiver services.

2. Actual costs will be determined on the basis of the information on the HCBS waiver cost report and obtained by the Department or its designee for the purposes of cost auditing.

    a. The costs submitted by the provider for the most recent available final cost report for a 12 month12-month period shall be used to determine the interim rates for the ensuing 12 month period effective July 1 of each year.

i. The interim rate will be calculated as total reported costs divided by total units per HCBS waiver service.

ii. An interim rate shall be determined for each HCBS waiver service provided.

iii. The most recent available final cost report will be used to set the next fiscal year's interim rates.

b. Reimbursement to State and local government HCBS waiver providers shall be adjusted retroactively after the close of each ~~12 month~~12-month period.

c. Total costs submitted by the provider shall be reviewed by the Department or its designee and result in a total allowable cost.

d. The Department will determine the total interim payment through the MMIS.

e. The Department will reconcile interim payments to the total allowable and make adjustments to payments as necessary. Interim payments shall be paid through the MMIS.

3. Submission of the HCBS waiver cost report shall occur annually for costs incurred during the prior fiscal year.

a. The cost report for HCBS waiver services must be submitted to the Department annually on October 31 to reflect costs from July 1-June 30.

b. The cost report will determine the final adjustment to payment for the period for which the costs were reported.

c. Reconciliation to align the fiscal year reimbursement with actual fiscal year costs after the close of each fiscal year shall be determined by the Department annually.

e. A State or local government HCBS waiver provider may request an extension of time to submit the cost report. The request for extension shall:

i. Be in writing and shall be submitted to the Department.

ii. Document the reason for failure to comply.

iii. Be submitted no later than ten (10) working days prior to the due date for submission of the cost report.

f. Failure of a State or local government HCBS waiver provider to submit the HCBS waiver cost report by October 31 shall result in the Department withholding all warrants not yet released to the provider as described below:

i. When a State or local government HCBS waiver provider fails to submit a complete and auditable HCBS waiver cost report on time, the HCBS waiver cost report shall be returned to the facility with written notification that it is unacceptable.

1. The State or local government HCBS waiver provider shall have either 30 days from the date of the notice or until the end of the

cost report submission period, whichever is later, to submit a corrected HCBS waiver cost report.

2. If the corrected HCBS waiver cost report is still determined to be incomplete or un-auditable, the State or local government HCBS waiver provider shall be given written notification that it shall, at its own expense submit a HCBS waiver cost report prepared by a Certified Public Accountant (CPA). The CPA shall certify that the report is in compliance with all Department rules and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

3. The Department may withhold all warrants not yet released to the provider when the original cost report submission period and 30-day extension have expired and an auditable HCBS waiver cost report has not been submitted.

ii. If the audit of the HCBS waiver cost report is delayed by the state or local government HCBS waiver provider's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall mean failure to provide documents, personnel or other resources within its control and necessary for the completion of the audit.

4. Non-allowable costs for State and local government providers offering HCBS waiver services include:

a. Room and Board;

b. Costs which have been allocated to an ICF/IID;

c. Costs for which there is either no supporting documentation or for which the supporting documentation is not sufficient to validate the costs;

d. Costs for services that are available through the Medicaid State Plan or provided on an HCBS waiver other than the HCBS-DD waiver ~~for Persons with Developmental Disabilities~~;

e. Costs for services that are not authorized on an approved HCBS-DD waiver ~~for Persons with Developmental Disabilities~~ PAR.

f. Costs for services that are not authorized by the Department as an HCBS waiver service;

g. Costs which are not reasonable, necessary, and ~~client~~Client related.

5. Adjustment(s) to the HCBS waiver cost report shall be made by the Department's contract auditor to remove reported costs that are non-allowable.

a. Following the completion of an audit of the cost report the Department or its contract auditor shall notify the affected State or local government HCBS waiver provider of any proposed adjustment(s) to the costs reported on the HCBS waiver cost report and include the basis of the proposed adjustment(s).

b. The provider may submit additional documentation in response to a proposed adjustment. The Department or its contract auditor must receive the additional documentation or other supporting information from the provider within 14 calendar days of the date of the proposed adjustments letter or the documentation will not be considered.

c. The Department may grant a reasonable period, no longer than 30 calendar days, for the provider to submit such documents and information, when necessary and appropriate, given the providers' particular circumstances.

d. The Department or its contract auditor shall complete the audit of the cost report within 30 days of the submission of documentation by the provider.

8.500.14.H Reimbursement for a Supported Employment Training Certificate or Certification, or both, under section 8.500.9.B.1.a, which includes both the cost of attending a training or obtaining a certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse Providers for such costs.

1. Providers seeking reimbursement for completed training or certification, or both, approved under section 8.500.9.B.1.a.ii, must submit the following to the Department:

a. Supported Employment Providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving a reimbursement request under section 8.500.14.H.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under section 8.500.9.B.1.a.ii.1.c and either notify the provider of the denial or, if approved, reimburse the provider.

a. Reimbursement is limited to the following amounts and includes reimbursement for wages:

i. Up to $300 per certification exam.

ii. Up to $1,200 for each training.

8.500.15 INDIVIDUAL RIGHTS

8.500.15.A Individual rights shall be in accordance with Sections 25.5-10-223 - 230~~27-10.5-101 C.R.S. *et seq*.~~, C.R.S.

8.500.16 APPEAL RIGHTS

The Case Management Agency shall meet the requirements set forth at Section 8.519.22.

8.500.16.A The CCB shall provide the ~~long term~~long-term care notice of action form to applicants and Clients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq*. When:

1. The Client or applicant is determined to not have a developmental disability,

2. The Client or applicant is found eligible or ineligible for LTSS,

3. The Client or applicant is determined eligible or ineligible for placement on a waiting list for LTSS,

4. An adverse action occurs that affects the Client's or applicant's waiver enrollment status,

8.500.16.B The CCB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CCB has made a denial or adverse action against a Client.

8.500.16.C The CCB shall notify the Case Management Agency in the ~~client~~Client's service plan within one (1) business day of the adverse action.

8.500.16.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.16.E The applicant or Client shall be informed of an adverse action if the Client or applicant is determined ineligible and the following:

1. The Client or applicant is detained or resides in a correctional facility, or

2. The Client or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

8.500.17 QUALITY ASSURANCE

8.500.17.A The monitoring HCBS-DD Waiver services and the health and well-being of service recipients shall be the responsibility of the Operating Agency, under the oversight of the Department.

8.500.17.B The Operating Agency, shall conduct reviews of each agency providing HCBS-DD w~~W~~aiver services or cause to have reviews to be performed in accordance with guidelines established by the Department or Operating Agency. The review shall apply rules and standards developed for programs serving individuals with intellectual or developmental disabilities.

8.500.17.C The Operating Agency shall maintain or cause to be maintained for three ~~(3)~~ years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-DD w~~W~~aiver programs or the delivery of services. The Department shall have access to these records at any reasonable time.

8.500.17.D The Operating Agency shall recommend to the Department the suspension of payment, denial or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond by submitting a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.17.E After having received the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action within a reasonable timeframe agreed upon the Department and the Operating Agency.

8.500.18 CLIENT PAYMENT - POST ELIGIBILITY TREATMENT OF INCOME

8.500.18.A A ~~client~~Client who is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard at ~~10 CCR 2505-10 §~~Section 8.100.7.A, is required to pay a portion of the ~~client~~Client's income toward the cost of the ~~client~~Client's HCBS-DD services after allowable income deductions.

8.500.18.B This Post Eligibility Treatment of Income(PETI) assessment shall:

1. Be calculated by the Case Management Agency using the form specified by the Operating Agency.

2. Be calculated during the ~~client~~Client's initial or continued stay review for HCB-DD services;

3. Be recomputed as often as needed, by the case management agency in order to ensure the ~~client~~Client's continued eligibility for the HCBS-DD waiver;

8.500.18.C In calculating PETI assessment, the case management agency must deduct the following amounts, in the following order, from the individual's total income including amounts disregarded in determining Medicaid eligibility:

1. A maintenance allowance equal to 300% the current and/SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty-~~-~~five dollars ($245) per month;

2. For a ~~client~~Client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

3. For a ~~client~~Client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate TANF~~AFDC~~ grant level; and

4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

   a. Health insurance premiums (other than Medicare), deductibles. or coinsurance charges (including Medicaid copayments); and

   b. Necessary medical or remedial care recognized under State law but not covered under the Medicaid State Plan.

8.500.18.D Case Management Agencies are responsible for informing individuals of their PETI obligation on a form prescribed by the Operating Agency.

8.500.18.E PETI payments and the corresponding assessment forms are due to the Operating Agency during the month following the month for which they are assessed.

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community-Based Supported Living Services (HCBS-SLS) waiver. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

HCBS-SLS services and supports which are available to assist persons with intellectual or developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an HCBS-SLS setting. HCBS-SLS waiver services are not intended to provide ~~twenty four~~twenty-four (24) hours of paid support or meet all identified Client needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-SLS waiver or a specific HCBS-SLS waiver service(s).

C. APPLICANT means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.

E. CASE MANAGEMENT AGENCY(CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

F. CLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

G. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or, (B) an individual, family member or friend selected by the Client to speak for and/or act on the Client's behalf.

H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

I CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

J. COST CONTAINMENT means limiting the cost of providing care in the community to 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, and Medicaid State Plan Benefits including long-term home health services, and targeted case management.

K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and includes the following:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a Client with an intellectual or developmental disability has been given by a court; or,

A spouse; or

The Client's children.

Q. FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for long-term services and supports as determined by the Department' s prescribed instrument.

R. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long-t-Term Care instrument and medical verification on the professional medical information page to determine if the applicant or Client meets the institutional Level of Care (LOC).

S. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

T. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Aarticle 33 of Ttitle 22, C.R.S.

U. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

V. INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) for which the Department makes Medicaid payment under the Medicaid State Plan.

W. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a public or private facility that provides health and habilitation services to a Client with intellectual or developmental disabilities or related conditions.

X. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.

Y. LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a Client must require in order to receive services in an institutional setting under the state plan.

Z. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illness who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

AA. MEDICAID ELIGIBLE means an applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

BB. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the State covers, and how the State addresses additional Federal Medicaid statutory requirements concerning the operation of its Medicaid program.

CC. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

DD. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in a Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

EE. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), Home and Community-Based Services Supported Living Services (HCBS-SLS) and Home and Community-Based Services Children's Extensive Support (HCBS-CES) waivers.

FF. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent or the Case Management Agency.

GG. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) ~~means the medical information document signed by a licensed medical professional used as a component of the Level of Care evaluation to determine the Clients need for LTSS program.~~ means the medical information form

signed by a licensed medical professional used to certify the Applicant's or Client's need for long-term care services.

HH. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received program approval to provide HCBS-SLS services.

II. PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use including vehicles for hire.

JJ. REIMBURSMENT RATES means the maximum allowable Medicaid reimbursement to a provider for each unit of service.

KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the Client received services according to the service plan and that the Case Management Agency complied with requirements set forth in statute, waiver and regulation.

MM. SERVICE DELIVERY OPTION means the method by which direct services are provided for a Client and include a) by an agency and b) Client directed.

NN. SERVICE PLAN means the written document that specifies identified and needed services to include Medicaid eligible and non-Medicaid eligible services, regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.

OO. SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

PP. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

QQ. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi- structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

RR. SUPPORT LEVEL means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

SS. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive

assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

TT. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid that may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

UU. WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State plan benefits.

8.500.91 HCBS-SLS WAIVER ADMINISTRATION

8.500.91.A HCBS-SLS shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities, 2 CCR 503-1 and promulgated in accordance with the provision of Section 25.5-6-404 (4), C.R.S.

8.500.91.B In the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the provisions of Section 25.5-6-404(4), C.R.S. shall apply and the regulations of the Department shall control.

8.500.10.C The HCBS-SLS wWaiver is operated by the ~~Department of Human Services, Division for Developmental Disabilities under the oversight of~~ the Department of Health Care Policy and Financing.

8.500.910.E HCBS-SLS services are available only to address those needs identified in the functional needs assessment and authorized in the service plan when the service or support is not available through the Medicaid State plan, EPSDT, natural supports, or third party payment resources.

8.500.91.F The HCBS-SLS Waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments into the HCBS-SLS wWaiver do not exceed the federally approved waiver capacity, and

4. May limit the enrollment when utilization of the HCBS-SLS wWaiver program is projected to exceed the spending authority.

8.500.92 GENERAL PROVISIONS

8.500.92.A The following provisions shall apply to the Home and Community-Based Services-Supported Living Services (HCBS-SLS) wWaiver:

1. HCBS-SLS shall be provided as an alternative to ICF-~~MR~~ IID services for an eligible C~~c~~lient with intellectual or developmental disabilities.

2. HCBS-SLS is waived from the requirements of Section 1902 (a)(10)(b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the State of Colorado.

3. A ~~client~~Client enrolled in the HCBS-SLS w~~W~~aiver shall be eligible for all other Medicaid services for which the ~~client~~Client qualifies and shall first access all benefits available under the Medicaid State plan or Medicaid EPSDT prior to accessing services under the HCBS-SLS w~~W~~aiver. Services received through the HCBS-SLS w~~W~~aiver may not duplicate services available through the State Plan

8.500.93 CLIENT ELIGIBILITY

8.500.93.A To be eligible for the HCBS-SLS w~~W~~aiver an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability

2. Be eighteen (18) years of age or older,

3. Does not require twenty-four (24) hour supervision on a continuous basis which is reimbursed as a HCBS-SLS service,

4. Is served safely in the community with the type or amount of HCBS-SLS waiver services available and within the federally approved capacity and cost containment limits of the waiver,

5. Meet ICF-~~MR~~IID level of care as determined by the Functional Needs Assessment

6. Meet the Medicaid financial determination for LTC eligibility as specified at ~~10 CCR 2505-10,~~ Section 8.100 ~~*et seq.*~~; and,

7. Reside in an eligible HCBS-SLS setting. SLS settings are the C~~c~~lient's residence, which is defined as the following:

   a. A living arrangement, which the C~~c~~lient owns, rents or leases in own name,

   b. The home where the ~~client~~Client lives with the C~~c~~lient's family or legal guardian, or

   c. A living arrangement of no more than three (3) persons receiving HCBS-SLS residing in one household, unless they are all members of the same family.

8. The C~~c~~lient shall maintain eligibility by continuing to meet the HCBS-SLS eligibility requirements and the following:

   a. Receives at least one (1) HCB-SLS waiver service each calendar month,

   b. Is not simultaneously enrolled in any other HCBS waiver, and

   c. Is not residing in a hospital, nursing facility, ICF-~~MR~~IID, correctional facility or other institution.

9. When the HCBS-SLS waiver reaches capacity for enrollment, a ~~client~~Client determined eligible for a waiver shall be placed on a wait list in accordance with these rules ~~,~~ at ~~10 CCR 2505-10,~~ Section 8.500.96 ~~et seq~~.

8.500.94 HCBS-SLS WAIVER SERVICES

8.500.94.A. SERVICES PROVIDED

1. Assistive Technology

2. Behavioral Services

3. Day Habilitation services and supports

4. Dental Services

5. Health Maintenance

6. Home Accessibility Adaptations

7. Home Delivered Meals

8. Homemaker Services

9. Life Skills Training (LST)

10. Mentorship

11. Non-Medical Transportation

12. Peer Mentorship

13. Personal Care

14. Personal Emergency Response System (PERS)

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

16. Respite

17. Specialized Medical Equipment and Supplies

18. Supported Employment

19. Transition Setup

20. Vehicle Modifications

21. Vision Services

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

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

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

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

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

d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-SLS w~~W~~aiver, and

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

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

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

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

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

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

i) Purchase, training or maintenance of service animals,

ii) Computers,

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

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

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

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

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

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

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

d. Behavioral Services:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Preventative services include:

i) Dental insurance premiums and co-payments

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

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

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

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

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

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

ii) Crowns

iii) Bridges

iv) Dentures

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

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

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

g. Full mouth implants or crowns are not covered.

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

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

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

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

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

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

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

c. Mouth care performed when:

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

ii) in the presence of communicable disease,

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

iv) oral suctioning is required,

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

e. Feeding

i) When suctioning is needed on a stand-by or other basis,

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

iii) Syringe feeding, OR

iv) Feeding using an apparatus,

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

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

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

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

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

k. Respiratory care, including:

i. Postural drainage,

ii) Cupping,

iii) Adjusting oxygen flow within established parameters,

iv) Suctioning of mouth and nose,

v) Nebulizers,

vi) Ventilator and tracheostomy care,

vii) Prescribed respiratory equipment.

8.500.94.B.6. HOME ACCESSIBILITY ADAPTATIONS

8.500.94.B.6.a DEFINITIONS

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

Case Manager means a person who provides case management services and meets all regulatory requirements for case managers.

The Division of Housing (DOH) is a division within the Colorado Department of Local Affairs that is responsible for approving Home Accessibility Adaptation PARs, oversight on the quality of Home Accessibility Adaptation projects, and inspecting Home Accessibility Adaptation projects, as described in these regulations.

1. DOH oversight is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, all oversight functions shall be performed by the Department unless specifically allowed by the Participant or their guardian to be performed by DOH.

Home Accessibility Adaptations means the most cost-effective physical modifications, adaptations, or improvements in a Participant's existing home setting which, based on the Participant's medical condition or disability: Participant

1. Are necessary to ensure the health and safety of the Participant;

2. Enable the Participant to function with greater independence in the home; or

3. Prevent institutionalization or support the deinstitutionalization of the Participant.

Home Accessibility Adaptation Provider means a provider agency that meets the standards for Home Accessibility Adaptation described in /Section 8.500.94.B.6.e and is an enrolled Medicaid provider.

Person-Centered Planning means Home Accessibility Adaptations that are agreed upon through a process that is driven by the Participant and can include people chosen by the Participant, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations; and where the Participant is provided necessary information, support, and choice Participant to ensure that the Participant directs the process to the maximum extent possible.

8.500.94.B.6.b INCLUSIONS

8.500.94.B.6.b.i Home Accessibility Adaptations may include, but are not limited to the following:

a) Installing or building ramps;

b) Installing grab-bars or other Durable Medical Equipment (DME) if such installation cannot be performed by a DME supplier;

c) Widening or modification of doorways;

d) Modifying a bathroom facility for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

e) Modifying a kitchen for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

f) Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies;,

g) Installing stair lifts or vertical platform lifts;

h) Modifying an existing second exit or egress window to lead to an area of rescue for emergency purposes;

i) The modification of a second exit or egress window must be approved by the Department or DOH at any funding level as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the Participant.

i) Safety enhancing supports such as basic fences, strengthened windows, and door and window alerts.

8.500.94.B.6.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of Section 8.500.94.B.6.

8.500.94.B.6.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.

8.500.94.B.6.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.

8.500.94.B.6.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.

a) Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the Participant, or enable the Participant to function with greater independence in the home, if:

i) The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and

ii) Either:

1. There is an immediate risk to the Participant's health or safety, or

2. There has been a significant change in the Participant's needs since a previous Home Accessibility Adaptation.

b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule at Ssection 8.500.94.B.6.

8.500.94.B.6.c. EXCEPTIONS AND RESTRICTIONS

8.500.94.B.6.c.i. Home Accessibility Adaptations must be a direct benefit to the Participant and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.

8.500.94.B.6.c.ii. Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, are prohibited.

8.500.94.B.6.c.iii. Adaptations, improvements, or modifications as a part of new construction costs are prohibited.

a) Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.

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

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

ii) configure a bathroom to accommodate a wheelchair.

c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department requirements found in this rule at sSection 8.500.94.B.6.

8.500.94.B.6.c.iv. The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.

8.500.94.B.6.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.

8.500.94.B.6.c.vi. Upgrades beyond what is the most cost-effective means of meeting the Participant's identified need, including, but not limited to items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

8.500.94.B.6.c.vii. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

a) Roof repair,

b) Central air conditioning,

c) Air duct cleaning,

d) Whole house humidifiers,

e) Whole house air purifiers,

f) Installation or repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,

g) Monthly or ongoing home security monitoring fees,

h) Home furnishings of any type,

i) HOA fees.

8.500.94.B.6.c.viii. Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.

8.500.94.B.6.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.500.94.B.6.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to ~~§~~Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.500.94.B.6.d CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.500.94.B.6.d.i. The Case Manager shall consider alternative fund-ing sources to complete the Home Accessibility Adaptation. The alternatives considered and the reason they are not available shall be documented in the case record.

1) The Case Manager must confirm that the Participant is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding. Case Managers may request confirmation of a property owner's obligations through DOH.

8.500.94.B.6.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval and confirmation of Home Accessibility Adaptation fund availability.

8.500.94.B.6.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization Request form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6. Home Accessibility Adaptations submitted with improper documentation will not be approved.

2) The Case Manager and CMA are responsible for retaining and tracking all documentation related to a Participant's Home Accessibility Adaptation funding use and communicating that information to the Participant and Home Accessibility Adaptation providers. The Case Manager may request confirmation of a Participant's Home Accessibility Adaptation fund use from the Department or DOH.

3) The Case Manager shall discuss any potential plans to move to a different residence with the Participant or their guardian and advise them on the most prudent utilization of available funds.

8.500.94.B.6.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1) An occupational or physical therapist (OT/PT) shall assess the Participant's needs and the therapeutic value of the requested Home Accessibility Adaptation. When an OT/PT with experience in Home Accessibility Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Accessibility Adaptation would contribute to a Participant's ability to remain in or return to his/her home, and how the Home Accessibility Adaptation would increase the Participant's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

a) The evaluation must be performed in the home to be modified. If the Participant is unable to access the home to be modified without the modification, the OT/PT must evaluate the Participant and home separately and document why the Participant was not able to be evaluated in the home.

2) The evaluation may be provided by a home health agency or other qualified and approved OT/PT through the Medicaid Home Health benefit.

a) A Case Manager may initiate the OT/PT evaluation process before the Participant has been approved for

waiver services, as long as the Participant is Medicaid eligible.

b) A Case Manager may initiate the OT/PT evaluation process before the Participant physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

c) OT/PT evaluations performed by non-enrolled Medicaid providers may be accepted when an enrolled Medicaid provider is not available. A Case Manager must document the reason why an enrolled Medicaid provider is not available.

3) The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Participant's needs. The Case Manager shall document these alternatives and why they did not meet the Participant's needs in the Participant's case file.

8.500.94.B.6.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:

1) The Case Manager shall assist the Participant in soliciting bids from at least two Home Accessibility Adaptation Providers for Home Accessibility Adaptations estimated to cost $2,500 or more. Participant choice of provider shall be documented throughout.

2) The Case Manager must verify that the provider is an enrolled Home Accessibility Adaptation Provider for Home Accessibility Adaptations.

4) The bids for Home Accessibility Adaptations at all funding levels shall include a breakdown of the costs of the project and the following:

a) Description of the work to be completed,

b) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour,

c) Estimate for building permits, if needed,

d) Estimated timeline for completing the project,

e) Name, address and telephone number of the Home Accessibility Adaptation Provider,

f) Signature, physical or digital, of the Home Accessibility Adaptation Provider,

g) Signature, physical or digital, or other indication of approval, such as email approval, of the Participant or their guardian, that indicates all aspects of the bid have been reviewed with them,

h) Signature, physical or digital of the home owner or property manager if the home is not owned by the Participant or their guardian.

5) Home Accessibility Adaptation Providers have a maximum of thirty (30) days to submit a bid for the Home Accessibility Adaptation project after the Case Manager has solicited the bid.

a) If the Case Manager has made three attempts to obtain a bid from a second Home Accessibility Adaptation Provider and the provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

6) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.500.94.B.6. and the recommendations of the OT/PT evaluation.

a) If a Participant or home-owner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

7) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.500.94.B.6.

8.500.94.B.6.d.vi. If a property to be modified is not owned by the Participant, the Case Manager shall obtain physical or digital signatures from the home-owner or property manager on the submitted bids authorizing the specific modifications described therein.

1) Written consent of the home-owner or property manager is required for all projects that involve permanent installation within the Participant's residence or installation or modification of any equipment in a common or exterior area.

2) The authorization shall include confirmation that the home owner or property manager agrees that if the Participant vacates the property, the Participant may choose to either leave the modification in place or remove the modification, that the home owner or property manager may not hold any party responsible for removing all or part of a Home Accessibility Adaptation project, and that if the Participant chooses to remove the modification, the property must be left in equivalent or better than its pre-modified condition.

8.500.94.B.6.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation, the Department may hold the CMA financially liable for the increased cost.

8. 500.94.B.6.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR. Visit may be completed using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk (e.g. natural disaster, pandemic, etc.).

8.500.94.B.6.e PROVIDER RESPONSIBILITIES

8.500.94.B.6.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in Section 8.500.98.

8.500.94.B.6.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the ~~the~~ Home Accessibility Adaptation services will be performed, if required by that city or county.

8.500.94.B.6.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

1) If any changes to the approved scope of work are made without DOH or Department authorization, the cost of those changes will not be reimbursed.

2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi

8.500.94.B.6.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's expense.

1) The provider shall give the Participant or their guardian all manufacturer's or seller's warranties on completion of work.

8.500.94.B.6.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications (2018) developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8.500.94.B.6.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Accessibility Adaptation projects may be inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. Participants must provide access for inspections.

1) DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion for sampled projects, or receipt of a Participant's reasonable request.

2) DOH shall produce a written inspection report within the time frame agreed upon in the Home Accessibility Adaptations work plan that notes the Participant's specific complaints. The inspection report shall be sent to the Participant, Case Manager, and provider.

3) Home Accessibility Adaptation Providers must repair or correct any noted deficiencies within twenty (20) days or the time required in the inspection report, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

8.500.94.B.6.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis for non-payment or recovery of payment by the Department.

1) Volunteer work on a Home Accessibility Adaptation project approved by the Department shall be completed under the supervision of the Home Accessibility Adaptation Provider as stated on the bid.

a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family of the Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

8.500.94.B.6.f REIMBURSEMENT

8.500.94.B.6.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments.

8.500.94.B.6.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8.500.94.B.6.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation to DOH:

1) Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2) Required permits;

3) One-year written warranty on materials and labor; and

4) Documentation in the Participant's file that the Home Accessibility Adaptation has been completed satisfactorily through:

a) Receipt of the inspection report approving work from the state, county, or local building, plumbing, or electrical inspector;

b) Approval by the Participant, representative, or other designee;

c) Approval by the home-owner or property manager;

d) A final on-site inspection report by DOH or its designated inspector; or

e) DOH acceptance of photographs taken both before and after the Home Accessibility Adaptation.

8.500.94.B.6.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the ~~p~~provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8.500.94.B.6.f.v. The Home Accessibility Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.

1) All required repairs noted on inspections shall be completed before the Home Accessibility Adaptation Provider submits a final claim for reimbursement.

2) If a Home Accessibility Adaptation Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the provider during an inspection. The provider shall only be reimbursed for the value of the work completed satisfactorily.

a) A Home Accessibility Adaptation Provider may request DOH perform one (1) reconsideration of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the provider's expense.

8.500.94.B.6.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.

1) Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 7 day deadline and be supported by documentation, including Participant notification.

2) The Home Accessibility Adaptation reimbursement reduced pursuant to this subsection shall be considered part of the Participant's remaining funds.

8.500.94.B.6.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

7. Home Delivered Meals as defined at Section 8.553.1.

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

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

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

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

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

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

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

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

2) To increase the independence of the ~~client~~Client,

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

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

9. Life Skills Training (LST) as defined at Section 8.553.1.

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

a. Assistance in interviewing potential providers,

b. Assistance in understanding complicated health and safety issues,

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

d. Training in child and infant care for ~~client~~Clients who are parenting children.

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

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

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

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

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

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

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

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

12. Peer Mentorship as defined at Section 8.553.

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

a. Personal care services include:

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

ii) Assistance with money management,

iii) Assistance with menu planning and grocery shopping, and

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

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

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

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

ii. The ~~client~~Client shall be informed of the option to direct his/her health maintenance activities pursuant to Section 8.510, et seq.

14. Personal Emergency Response System (PERS) is an electronic device that enables ~~client~~Clients to secure help in an emergency. The ~~client~~Client may also wear a portable “help” button to allow for mobility. PERS services are covered when the PERS system is connected to the ~~client~~Client’s phone and programmed to a signal a response center

when a “help” button is activated, and the response center is staffed by trained professionals.

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

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

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

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

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

d. Professional services may be reimbursed only when:

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

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

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

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

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

i) Acupuncture,

ii) Chiropractic care,

iii) Fitness trainer

iv) Equine therapy,

v) Art therapy,

vi) Warm water therapy,

vii) Experimental treatments or therapies, and.

viii) Yoga.

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

a. Respite may be provided:

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

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

iii) In the community.

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

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

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

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

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

c. The following limitations to respite services shall apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Group employment including mobile crews or enclaves shall not exceed eight ~~client~~Clients.

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

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

h. Documentation of the ~~client~~Client's application for services through the Colorado Department of ~~Human Services~~Labor and Employment Division for Vocational Rehabilitation shall be maintained in the file of each ~~client~~Client receiving this service. Supported employment is not available under a program funded under

Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. Section 1400, et seq.).

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

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

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

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

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

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

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

19. Transition Setup as defined at Section 8.553.1.

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

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

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

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

ii) Purchase or lease of a vehicle, and

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

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

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

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

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

c. Prior authorized in accordance with Operating Agency procedures.

8.500.94.C PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES

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

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

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

i) Personal Care as defined at Section 8.500.94.B.12

ii) Homemaker services as defined at Section 8.500.94.B.8

iii) Health Maintenance Activities as defined at Section8.500.94.B.5

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

8.500.95 SERVICE PLAN:

The Case Management Agency shall complete a service plan for each ~~Client~~Client enrolled in the HCBS-SLS waiver in accordance with Section 8.519.11.B.2

8.500.95.D The Service Plan must be reported in the Department prescribed system and include the following employment information for individuals eligible for or receiving Supported Employment services, if applicable:

1. Sector and type of employment.

2. Mean wage per hour earned.

3. Mean hours worked per week.

8.500.96 WAITING LIST PROTOCOL

8.500.96.A When the federally approved waiver capacity has been met, persons determined eligible to receive services under the HCBS-SLS, shall be eligible for placement on a waiting list for services.

8.500.96.B Waiting lists for persons eligible for the HCBS-SLS waiver program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Operating Agency's procedures.

8.500.96.C Persons determined eligible shall be placed on the waiting list for services in the Community Centered Board service area of residency.

8.500.96.D Persons who indicate a serious intent to move to another service area should services become available shall be placed on the waiting list in that service area. Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in the Operating Agency's procedures for placement on a waiting list in a service area other than the area of residency.

8.500.96.E The date used to establish a person's placement on a waiting list shall be:

1. The date on which eligibility for developmental disabilities services in Colorado was originally determined; or

2. The fourteenth (14th) birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

8.500.96.F As openings become available in the HCBS-SLS waiver program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:

1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered and the emergency cannot be resolved in another way. Emergencies are defined as follows:

    a. Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode.

    b. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

    c. Danger to Others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

    d. Danger to Self: a person's medical, psychiatric or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

    e. The Legislature has appropriated funds specific to individuals or to a specific class of persons.

    f.. If an eligible individual is placed on a waiting list for SLS waiver services, a written notice, including information regarding the ~~client~~Client appeals process, shall be sent to the individual and/or his/her legal guardian in accordance with the provisions of Section 8.057, *et seq.*

8.500.97 CLIENT RESPONSIBILITIES

8.500.97.A A ~~client~~Client or the ~~client~~Client's family or guardian is responsible for:

1. Providing accurate information regarding the ~~client~~Client's ability to complete activities of daily living,

2. Assisting in promoting the ~~client~~Client's independence,

3. [no text]

4. Cooperating in the determination of financial eligibility,

5. Notifying the case manager within thirty (30) days after:

   a. Changes in the ~~client~~Client's support system, medical condition and living situation including any hospitalizations, emergency room admissions,

   b. Placement to a nursing home or intermediate care facility for the ~~mentally retarded~~individuals with intellectual disabilities (ICF-~~MR~~IID),

   c. The ~~client~~Client has not received an HCBS waiver service during one (1) month

   d. Changes in the ~~client~~Client's care needs,

   e. Problems with receiving HCBS-SLS waiver services, and

   f. Changes that may affect Medicaid financial eligibility including prompt report of changes in income or assets.

8.500.98 PROVIDER REQUIREMENTS

8.500.98.A A private for profit or not for profit agency or government agency shall meet minimum provider qualifications as set forth in the HCBS-SLS waiver and shall:,

1. Conform to all state established standards for the specific services they provide under HCBS-SLS,

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in ~~10 CCR 2505-10,~~ Section 8.130,

4. Discontinue HCBS-SLS services to a ~~client~~Client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

5. Have written policies governing access to duplication and dissemination of information from the ~~client~~Client's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S.~~, as amended,~~

6. When applicable, maintain the required licenses from the Colorado Department of Public Health And Environment, and

7. Maintain ~~client~~Client records to substantiate claims for reimbursement according to Medicaid standards.

8.500.98.B HCBS-SLS providers shall comply with:

1. All applicable provisions of Title 27, Article 10.5, C.R.S. ~~et seq~~, and the rules and regulations as set forth in Section 8.600. ~~2 CCR 503-1, 16.100 *et seq.*,~~:

2. All federal program reviews and financial audits of the HCBS-SLS waiver services,

3. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,

~~4. [no text]~~

~~5~~4. Requests from the county Departments of Social/Human Services to access records of ~~client~~Clients receiving services held by case management agencies as required to determine and re-determine Medicaid eligibility;

~~5~~6. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-SLS waiver, and

~~6~~7. Requests by the case management agency to monitor service delivery through targeted case management activities.

8.500.98.C Supported Employment provider training and certification requirements

1. Supported Employment service providers, including Supported Employment professionals who provide individual competitive integrated employment, as defined in 34 C.F.R. 361.5(c)(9) (2018), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and certification requirements. The incorporation of 34 C.F.R. 361.5(c)(9) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to ~~C.R.S. §~~ Section 24-4-103 (12.5) ~~(2018)~~, the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of the incorporated material will be provided at cost upon request.

   a. Subject to the availability of appropriations for reimbursement in section 8.500.104.G, Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

      i. Deadlines.

         1) Existing staff, employed by the Provider on or before July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

         2) Newly hired staff, employed by the Provider after July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

            a) Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

ii. Department approval required.

1) The Training Certificate or Certification required under section 8.500.98.C.1.a must be pre-approved by the Department.

a) Providers must submit the following information to the Department for pre-approval review:

i) Provider name.

ii) A current Internal Revenue Service Form W-9.

iii) Seeking approval for:

1. Training Certificate, or

2. Certification, or

3. Training Certificate and Certification.

iv) Name of training, if applicable, including:

1. Number of staff to be trained.

2. Documentation that the training is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

v) Name of Certification, if applicable, including:

1. Number of staff to receive Certification.

2. Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

vi) Dates of training, if applicable, including:

1. Whether a certificate of completion is received.

vii) Date of Certification exam, if applicable.

b) Department approval will be based on alignment with the following core competencies:

i) Core values and principles of Supported Employment, including the following:

1. The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.

ii) The Person-centered process, including the following:

1. The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-centered approach includes working with a team where the individual chooses the people involved on the team and receives: necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.

iii) Individualized career assessment and planning, including the following:

1. The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.

iv) Individualized job development, including the following:

1. Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.

v) Individualized job coaching, including the following:

1. Providing necessary workplace supports to ~~client~~Clients with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.

vi) Job Development, including the following:

1. Effectively engaging employers for the purpose of community job development for ~~client~~Clients with significant disabilities, which meets the needs of both the employer and the ~~client~~Client.

c) The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and notify the Provider of its determination within 30 days of receiving the pre-approval request under 8.500.98.C.1.a.ii.1.a.

8.500.99 TERMINATION OR DENIAL OF HCBS-SLS MEDICAID PROVIDER AGREEMENTS

8.500.99.A The Department may deny or terminate an HCBS-SLS Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at ~~10 CCR 2505-10,~~ Section 8.130 *et seq*,

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-SLS services,

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider,

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper ~~client~~Client notification,

5. Emergency termination of any provider agreement shall be in accordance with procedures at ~~10 CCR 2505-10,~~ S~~s~~ection 8.050, and

8.500.99.B The provider fails to comply with requirements for submission of claims pursuant to ~~10 CCR 2505-10,~~ Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

8.500.100 ORGANIZED HEALTH CARE DELIVERY SYSTEM

8.500.100.A The Organized Health Care Delivery System (OHCDS) for the HCBS-SLS waiver is the Community Centered Board as designated by the Operating Agency in accordance with Section~~s~~ 27-1010.5-103,.

8.500.100.B The OHCDS is the Medicaid provider of record for a ~~client~~Client whose services are delivered through the OHCDS,

8.500.100.C The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS according to the current federally approved waiver.

8.500.100.D The OHCDS may contract or employ for delivery of HCBS Waiver services.

8.500.100.E The OCHDS shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS Waiver,

2. Ensure that services are delivered according to the waiver definitions and as identified in the ~~client~~Client's service plan,

3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

4. Monitor the health and safety for HCBS ~~client~~Clients receiving services from a subcontractor.

8.500.100.F The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to ~~client~~Clients,

4. Negotiate rates that are in accordance with the Operating Agency's established fee for service rate schedule and Operating Agency procedures,

   a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

5. Collect and maintain the data used to develop provider rates and ensure data includes costs for services to address the ~~client~~Client's needs, that are allowable activities within the HCBS service definition and that supports the established rate,

6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency or Centers for Medicare and Medicaid Services (CMS), and

7. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.500.101 PRIOR AUTHORIZATION REQUESTS

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14

8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

8.500.102.A The service plan authorization limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a ~~client~~Client's ongoing service needs within one (1) service plan year.

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations, vehicle modifications, health maintenance activities available under the Consumer Directed Attendant Support Services (CDASS), home delivered meals, life skills training, peer mentorship, and transition setup.

8.500.102.C The total of all HCBS-SLS services in one service plan shall not exceed the overall authorization limitation as set forth in the federally approved HCBS-SLS waiver.

8.500.102.D Each SPAL is assigned a specific dollar amount determined through an analysis of historical utilization of authorized waiver services, total reimbursement for services, and the spending authority for the HCBS-SLS waiver. Adjustments to the SPAL amount may be determined by the Department and Operating Agency as necessary to manage waiver costs.

8.500.102.E Each SPAL is associated with six support levels determined by an algorithm which analyzes a ~~client~~Client's level of service need as determined by the SIS assessment and additional factors including exceptional medical and behavioral support needs and identification as a community safety risk.

8.500.102.F The SPAL determination shall be implemented in a uniform manner statewide and the SPAL amount is not subject to appeal.

8.500.103 RETROSPECTIVE REVIEW PROCESS

8.500.103.A Services provided to a ~~client~~Client are subject to a retrospective review by the Department and the Operating Agency. This retrospective review shall ensure that services:

1. Identified in the service plan are based on the ~~client~~Client's identified needs as stated in the functional needs assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a ~~client~~Client are in accordance with the service plan, and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

8.500.103.B When the retrospective review identifies areas of non compliance, the case management agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.103.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.500.103.D When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status

8.500.104 PROVIDER REIMBURSEMENT

8.500.104.A Providers shall submit claims directly to the Department's fiscal agent through the Medicaid management information system (MMIS); or through a qualified billing agent enrolled with the Department's fiscal agent.

8.500.104.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally approved HCBS-SLS waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance with the frequency, amount, scope and duration of the service as identified in the ~~client~~Client's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.104.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.104.D When the review identifies areas of non-compliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.104.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claim submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.104.F Except where otherwise noted, payment is based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin accessed through the Department's fiscal agent's web site.

8.500.104.G Reimbursement for Supported Employment Training Certificate or Certification, or both, under section 8.500.98.C.1.a, which includes both the cost of attending a training or obtaining a certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse providers for such costs.

1. Providers seeking reimbursement for a completed Training Certificate or Certification approved under section 8.500.98.C.1.a.ii.1.c must submit the following to the Department:

a. Supported Employment Providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving documentation under section 8.500.104.G.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under Ssection 8.500.98.C.1.a.ii and either notify the Provider of the denial or, if approved, reimburse the Provider.

a. Reimbursement is limited to the following amounts, and includes wages:

ii. Up to $300 per certification exam.

iii. Up to $1,200 for each training.

8.500.105 INDIVIDUAL RIGHTS

8.500.105.A The rights of a ~~client~~Client in the HCBS-SLS Waiver shall be in accordance with Sections 27-10.5-112 through 131, C.R.S.

8.500.106 APPEAL RIGHTS

Case Management Agencies shall meet the requirements set forth at Section 8.519.22

8.500.106.A The CCB shall provide the ~~long term~~long-term care notice of action form to applicants and ~~Client~~Clients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq*. when:

1. The ~~Client~~Client or applicant is determined to not have a developmental disability,

2. The ~~Client~~Client or applicant is found eligible or ineligible for LTSS,

3. The ~~Client~~Client or applicant is determined eligible or ineligible for placement on a waiting list for LTSS,

4. An adverse action occurs that affects the ~~Client~~Client's or applicant's waiver enrollment status; or,

8.500.106.B The CCB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CCB has made a denial or other adverse action against a ~~Client~~Client or applicant.

8.500.106.C The CCB shall notify the Case Management Agency in the ~~client~~Client's service plan within one (1) business day of the adverse action.

8.500.106.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.106.E The applicant or ~~Client~~Client shall be informed of an adverse action if the ~~Client~~Client is determined ineligible and the following:

1. The ~~Client~~Client or applicant s detained or resides in a correctional facility, or

2. The ~~Client~~Client or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

8.500.107 QUALITY ASSURANCE

8.500.107.A. The monitoring of services provided under the HCBS-SLS waiver and the health and well-being of ~~client~~Clients shall be the responsibility of the Operating Agency, under the oversight of the Department.

8.500.107.B. The Operating Agency shall conduct on-site surveys or cause to have on-site surveys to be done in accordance with guidelines established by the Department or the Operating Agency. The survey shall include a review of applicable Operating Agency rules and regulations and standards for HCBS-SLS.

8.500.107.C The Operating Agency, shall ensure that the case management agency fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.

8.500.107.D The Operating Agency, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials which pertain to the operation and service delivery of the SLS waiver program.

8.500.107.E The Operating Agency shall recommend to the Department the suspension of payment denial or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.107.F After receiving the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action.

8.500.108 CLIENT PAYMENT-POST ELIGIBILITY TREATMENT OF INCOME

8.500.108.A A ~~client~~Client who is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard at ~~10 CCR 2505-10 §~~Section 8.1100.7, is required to pay a portion of the ~~client~~Client's income toward the cost of the ~~client~~Client's HCBS-SLS services after allowable income deductions.

8.500.108.B This post eligibility treatment of income (PETI) assessment shall:

1. Be calculated by the case management agency during the ~~client~~Client's initial assessment and continued stay review for HCBS-SLS services.

2. Be recomputed, as often as needed, by the case management agency in order to ensure the ~~client~~Client's continued eligibility for the HCBS-SLS waiver

8.500.108.C In calculating PETI assessment, the case management agency must deduct the following amounts, in the following order, from the ~~client~~Client's total income including amounts disregarded in determining Medicaid eligibility:

1. A maintenance allowance equal to three hundred percent (300%) of the current SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty~~-~~ five dollars ($245) per month; and

2. For a ~~client~~Client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

3. For a ~~client~~Client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate ~~AFDC~~TANF grant level; and

4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

   a. Health insurance premiums (other than Medicare), deductibles. or coinsurance charges, (including Medicaid copayments)

   b. Necessary medical or remedial care recognized under state law but not covered under the Medicaid State Plan.

8.500.108.D Case management agencies are responsible for informing ~~client~~Clients of their PETI obligation on a form prescribed by the Operating Agency.

8.500.108.E PETI payments and the corresponding assessment forms are due to the Operation Agency during the month following the month for which they are assessed.

8.501 State Funded Supported Living Services Program

The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide supports to individuals with an intellectual or developmental disability to remain in their community. The State-SLS program shall not supplant Home and Community-~~-~~Based services for those who are currently eligible.

8.501.A Definitions

1. APPLICANT means an individual who is seeking supports from State-SLS program.

2. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-~~-~~Based Services waivers pursuant to section 25.5-10-209.5, C.R.S., has a valid provider participation agreement with the Department, and has a valid contract with the Department to provide these services.

3. CCB CASE MANAGER means the staff member of the Community Centered Board that works with individuals seeking services to develop and authorize services under the State-SLS program.

4. CLIENT means an individual who meets the DD Determination criteria and other State-SLS eligibility requirements and has been approved for and agreed to receive services in the State-SLS program.

5. CLIENT REPRESENTATIVE means a person who is designated by the ~~Client~~Client to act on the ~~Client~~Client's behalf. A ~~Client~~Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, or a spouse; or (B) an individual, family member or friend selected by the ~~client~~Client to speak for or act on the ~~client~~Client's behalf.

6. CORRECTIVE ACTION PLAN means a written plan, which includes the detailed description of actions to be taken to correct non-compliance with State-SLS requirements, regulations, and direction from the Department, and includes the date by which each action shall be completed and the individuals responsible for implementing the action.

7. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that meets the requirements set forth in S~~s~~ection 25.5.-10-209, C.R.S. and is responsible for conducting level of care evaluations and determinations for State-SLS services specific to individuals with intellectual and developmental disabilities.

8. COMMUNITY RESOURCE means services and supports that a ~~Client~~Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to, services provided through private insurance, non-profit services and other government programs.

9. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the ~~Client~~Client.

10. Developmental Disability (DD) Determination means the determination of a Developmental Disability as defined in section 8.607.2

11. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

12. DEVELOPMENTAL DISABILITY means a disability that is defined in section 8.600.4.

13. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).

14. HOME AND COMMUNITY-~~-~~BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a ~~Client~~Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

15. LONG-TERM CARE SERVICES AND SUPPORTS (LTSS) means the services and supports utilized by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

16. MEDICAID ELIGIBLE means an Applicant or ~~Client~~Client meets the criteria for Medicaid benefits based on a financial determination and disability determination.

17. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses federal Medicaid statutory requirements concerning the operation of its Medicaid program.

18. NATURAL SUPPORTS means an informal relationship that provides assistance and occurs in the ~~Client~~Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

19. PERFORMANCE AND QUALITY REVIEW means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by the CCB to ensure quality and compliance with all statutory and regulatory requirements.

20. PLAN YEAR mean a twelve (12) month period starting from the date when State-SLS Supports and Services where authorized.

21. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent.

22. PROGRAM APPROVED SERVICE AGENCY (PASA) means a developmental disabilities service agency or a service agency as defined in 8.602, that has received program approval, by the Department, to provide Medicaid Wavier services.

23. RELATIVE means a person related to the ~~Client~~Client by virtue of blood, marriage, or adoption.

24. RETROSPECTIVE REVIEW means the Department's review after services and supports are provided and the PASA is reimbursed for the service, to ensure the ~~client~~Client received services according to the service plan and standards of economy, efficiency and quality of service.

25. STATE-SLS INDIVIDUAL SUPPORT PLAN means the written document that identifies an individual's need and specifies the State-SLS services being authorized, to assist a ~~Client~~Client to remain safely in the community.

26. STATE FISCAL YEAR means a 12-month period beginning on July 1 of each year and ending June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in the calendar year.

27. Services and Supports or Supports and Services means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided to

    a. To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience person security and self-respect.

28. SUPPORT SERVICE means the service(s) established in the State SLS program that a CCB Case Manager may authorize to support an eligible ~~Client~~Client to complete the identified tasks identified in the ~~Client~~Client's Individualized Support Plan.

29. WAIVER SERVICE means optional services and supports defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.501.2 Administration:

1. The CCB shall administer the State-SLS program according to all applicable statutory, regulatory and contractual requirements, and Department policies and guidelines.

    a. The CCB is responsible for providing case management to all individuals enrolled in the State-SLS program.

    b. The CCB shall have written procedures related to the administration, case management, service provision, and waiting list for the State-SLS program.

    c. All records must be maintained in accordance with section 8.130.2.

    d. The CCB shall maintain a waiting list of eligible individuals for whom Department funding is unavailable in accordance with section 8.501.7.

    e. The CCB shall develop procedures for determining how and which individuals on the waiting list will be enrolled into the State-SLS program that comply with all applicable statutory, regulatory and contractual requirements including section 8.501.7.

    f. Any decision to modify, reduce or deny services or supports set forth in the State SLS program, without the Individual's or Guardian's agreement, are subject to the requirements in Section 8.605.

2. Eligibility

    a. General Eligibility requirements

        i. Individuals must be a resident of Colorado;

ii. Be eighteen (18) years of age or older; and

iii. Be determined to have an intellectual or developmental disability pursuant to the procedures set forth in section 8.607.2.

b. Eligibility for the State-SLS program does not guarantee the availability of services and supports under this program.

3. General Provisions

a. The availability of services offered through the State-SLS program may not be consistent throughout the State of Colorado or between CCBs.

b. An individual enrolled in the State-SLS program shall access all benefits available under the Medicaid State Plan, HCBS Waiver or EPSDT, if available, prior to accessing services under the State-SLS program. Services through the State-SLS program may not duplicate services provided through the State Plan when available to the ~~Client~~Client.

c. Evidence of attempts to utilize all other public benefits and available and accessible community resources must be documented in the State-SLS individualized Support Plan by the CCB Case Manager, prior to accessing State-SLS services or funds.

d. The State-SLS program shall be subject to annual appropriations by the Colorado General Assembly.

e. These regulations shall not be construed to prohibit or limit services and supports available to persons with intellectual and developmental disabilities that are authorized by other state or federal laws.

f. When an individual is enrolled only in the State-SLS program the CCB Case Manager shall authorize a Program Approved Service Agency (PASA) to deliver the services, when available.

g. When a PASA is not available the CCB Case Manager may authorize and provide the Support Service, through the State-SLS program, to assist the ~~Client~~Client with tasks identified in his or her Individual Support Plan.

h. The CCB Case Manager may authorize Services and Supports from multiple State-SLS service categories at once, unless otherwise stated.

i. Unless otherwise specified, State-SLS Services and Supports may be utilized in combination with other Community Resources and/or Medicaid Services and Supports, as long as they are not duplicative, and all other available and accessible resources are utilized first.

4. Performance and Quality Review

a. The Department shall conduct a Performance and Quality Review of the State-SLS program to ensure that the CCB is in compliance with all statutory and regulatory requirements.

b. A CCB found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but not limited to:

i. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;

ii. A detailed time-frame for completing the actions to be taken;

iii. The employee(s) responsible for implementing the actions; and

iv. The estimated date of completion.

c. The CCB shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The CCB shall explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.

i. Upon receipt of the proposed Corrective Action Plan, the Department will notify the CCB in writing whether the Corrective Action Plan has been accepted, modified, or rejected.

ii. In the event that the Corrective Action Plan is rejected, the CCB shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

iii. The CCB shall begin implementing the Corrective Action Plan upon acceptance by the Department.

iv. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.501.3 CCB and PASA Reimbursement

1. A PASA must submit all claims, payment requests, and/or invoices to the CCB for payment within thirty (30) days of the date of service, except for Services and Supports rendered in June, the last month of the State Fiscal Year. All claims, payment requests, and/or invoices for Services and Supports rendered in June must be submitted by the date specified by the CCB to ensure payment.

2. CCBs must submit all claims, payment requests, and/or invoices in the format and timeframe established by the Department.

3. CCB's and PASA's claims, payment requests, or invoices for reimbursement shall be made only when the following conditions are met:

a. Services and Supports are provided by a qualified PASA.

b. Services and Supports are authorized and delivered in accordance with the frequency, amount, scope and duration of the service as identified in the ~~Client~~Client's State-SLS Individual Support Plan;

c. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the State-SLS Individual Support Plan and in accordance with the service definition;

d. All case management activities must be documented and maintained by the CCB.

1. CCBs and PASAs shall maintain records in accordance with Section 8.130.2.

2. CCB and PASA reimbursement shall be subject to review by the Department and may be completed after the payment has been made to the CCB and PASA. CCBs and PASAs are subject to all program integrity requirements in accordance with section 8.076.

3. The reimbursement for this service shall be established in the Department's published fee schedule.

4. Except where otherwise noted, PASA reimbursement shall be based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private PASAs and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the PASA bulletin and can be accessed through the Department's fiscal agent's web site.

a. State-SLS rates shall be set and published in the provider bulletin annually each State Fiscal Year.

8.501.4 State-SLS Covered Services and Supports

8.501.4.A. Supports for Individuals waiting for HCBS waiver enrollment.

1. Eligible ~~Client~~Clients may receive the following Services and Supports

a. All Services and Supports identified in the HCBS-SLS waiver identified in section 8.500.94

b. Service limitations in the HCBS-SLS waiver and set forth in section 8.500 apply to the State-SLS program.

c. When a PASA is not available to provide Supports and Services the CCB may authorize the Support Services, to provide the needed Supports and Services identified in the State-SLS Individual Support Plan.

8.501.4.B Supports for Individuals Experiencing Temporary Hardships

1. State-SLS may be utilized to provide the following temporary Supports and Services to Individuals who have been determined to meet the criteria for an Intellectual / Developmental Disability as specified in Section 8.607.2, in situations where temporary assistance can alleviate the need for a higher level of care. These Services and Supports cannot be duplicative and shall not be accessed if available through other sources. In order to access State-SLS, an Individual Support Plan must be completed.

a. Payment of utilities:

i. Paying gas/electric bills and/or water/sewer bills:

Documentation must be maintained by the CCB that all alternative programs, community support, and Natural Supports were utilized before any State-SLS funds were authorized.

b. Supports with acquiring emergency food, at a retail grocery store when there are no other community resources available

i. Documentation must be maintained by the CCB demonstrating the reason why State-SLS funds were utilized over other sources of emergency food. This may include but is not limited to:

1) Other emergency food programs are not available.

2) Home delivered meals have unexpectedly stopped.

c. Pest infestation abatement:

i. Documentation must be maintained by the Case Manager showing that infestation abatement is not covered under the ~~Client~~Client's residential agreement or lease.

ii. Documentation that the pest abatement professional is licensed in the state of Colorado, must be maintained by the CCB and provided to the Department upon request.

iii. Pest infestation abatement shall not be authorized if the ~~Client~~Client resides in a PASA owned and/or controlled property.

iv. Documentation showing proof of payment must be maintained by the CCB administering the State-SLS program;

2. Service Limitations

a. Support for utilities shall not exceed $1000.00 in a State Fiscal Year.

b. Support for pest infestation abatement shall not exceed $2000.00 in a State Fiscal Year;

i. Supports for pest infestation abatement shall not cover more than one infestation event in a State Fiscal Year; and

ii. Multiple treatments per event may be authorized, if determined necessary by a licensed pest abatement professional.

iii. Emergency food support shall not exceed $400.00 in a State Fiscal Year.

8.501.4.C Supporting Independence in the Community.

1. State-SLS may be utilized to provide an individual found eligible for or enrolled in an HCBS Medicaid waiver, with a one-time payment or acquisition of needed household items, in the event the ~~Client~~Client is moving into a residence as defined in Section 8.500.93.A.(7).

a. State-SLS funds may be utilized for payment or acquisition of

i. initial housing costs including but not limited to a one-time initial set up for pantry items and/or kitchen supplies and/or furniture purchase.

b. Individuals enrolled in the HCBS-DD waiver residing in an Alternative Care Facility (ACF), Group Residential Supports and Services (GRSS) or Individual Residential Supports and Services - Host Home (IRSS-HH) setting are not eligible for this Support.

2. State-SLS funds may support someone to have greater independence when they are moving into their own home, by paying for housing application fee.

3. The CCB shall maintain receipts or paid invoices for purchases authorized in this section. Receipts or paid invoices must contain at a minimum, the following information: business name, item(s) purchased, item(s) cost, date paid, and description of items purchased. Documentation must be made available to the Department upon request. All items must be purchased from an established retailer that has a valid business license.

4. Service limitations

a. The one-time furniture purchase shall not exceed $300.00.

b. The one-time initial pantry set up shall not to exceed $100.00.

c. The one-time purchase of kitchen supplies shall not to exceed $200.00.

d. The payment of housing application fees are limited to five (5) in a State Fiscal Year.

8.501.4.D On-going State-SLS Support.

1. State-SLS funds may be authorized by the CCB for individuals who have been determined to meet the DD Determination requirements, but do not meet the requirements to be enrolled in HCBS-SLS Waiver section 8.500.93.

a. An eligible ~~client~~Client may be authorized to receive any service set forth in the HCBS-SLS waiver regulation at section 8.500.90.

b. Service limitation and service rules found in the HCBS-SLS waiver regulation at section 8.500.90 applies to the State SLS program.

c. A Program Approved Service Agency (PASA) is authorized to provide State-SLS services; and

2. When an individual is enrolled in an HCBS waiver, other than the HCBS-DD or HCBS-SLS waiver and needed Supports and Services not provided by that waiver, the CCB may authorize State-SLS funds.

a. A comparable service must not be available in the enrolled waiver.

b. State-SLS funds may not be utilized for Home Accessible Adaptation, or Vehicle Modification.

c. Only a PASA shall provide these services.

3. Service Limitation

a. Total authorization limit for the plan year shall be determined by the Departments and be communicated annually on the State-SLS Program rate schedule.

8.501.4.E State-SLS Individual Support Plan.

1. State-SLS ~~Client~~Clients are required to have a State SLS Individual Support Plan that is signed and authorized by the CCB Case Manager and the ~~Client~~Client, or their Guardian.

2. The State-SLS Individual Support Plan shall be developed through an in-person face to face meeting that includes at least, the individual seeking services and the CCB Case Manager. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.

3. If a Client seeks additional supports or alleges a change in need, the State-SLS Individual Support Plan shall be reviewed and updated by the CCB Case Manager prior to any change in authorized services and supports.

4. The State-SLS Individual Support Plan shall be effective for no more than one year and reviewed at least every 6 months, in a face-to-face meeting with the Client or on a more frequent basis if a change in need occurs. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.

a. Any changes to the provision of the services and supports identified in the State-SLS Individual Support Plan are subject to available funds within the designated service area.

b. Any decision to modify, reduce or deny services and supports set forth in the State-SLS Individual Support Plan, without the Client's consent is subject to the Dispute Resolution Process found in section 8.605.2.

5. The State-SLS Individual Support Plan and all supporting documentation will be maintained by the case manager and will be made available to the Department upon request.

6. The State-SLS Individual Support Plan shall include the following;

a. The Supports and Services authorized, the Client's identified needs and how the Supports and Service will address the needs.

b. The scope, frequency, and duration of each service.

c. Documentation demonstrating if other public or community resources have been utilized and why State-SLS funds are being utilized instead of or in combination with other resources.

d. Total cost of the supports being authorized.

e. Information to support authorization of services under Supports for Individuals Experiencing Temporary Hardships, including:

i. A description of the hardship.

ii. The reason for the hardship.

iii. The length of time the support will be authorized, including the date of the onset of the hardship and the date it is expected to end.

iv. Total amount needed to support the individual and what other community resources are contributing.

v. A plan to reasonably ensure the hardship is temporary.

vi. A plan to reasonably ensure that dependence on State-SLS funds will be temporary.

vii. The dates of when the long-term solution will be in place and when the temporary hardship is expected to end.

viii. Documentation demonstrating how utilizing State-SLS funds will lead to the Client gaining more independence in the community or maintaining their independence in the community.

f. Additional Information required for authorization of services for the purpose of Supporting Independence in the Community:

i. Total amount needed to support the individual and what other community resources are contributing.

g. Additional Information to be included for authorization of services On-going State -SLS Supports;

i. Documentation demonstrating why the individual enrolled in State-SLS is not eligible or enrolled in a HCBS Medicaid waiver or documentation showing which HCBS waiver the individual is enrolled in; and

ii. Documentation demonstrating how authorized services are not duplicative or comparable to others the individual is eligible for or has access to.

8.501.5 Case Management Services

8.502.5.A Administration

1. CMAs shall comply with all requirements set forth in section 8.607.1.

8.501.5.B Case Management Duties:

1. The case manager shall coordinate, authorize and monitor services based on the approved State-SLS Individual Support Plan.

a. The case manager shall have, based on the Client's preference, a face to face or telephone contact once per quarter with the Client.

2. The CCB Case Manager shall assist Clients to gain access to other resources for which they are eligible and to ensure Clients secure long-term support as efficiently as possible.

3. The CCB Case Manager shall provide all State-SLS documentation upon the request from the Department.

4. Referrals to the State-SLS program shall be made through the CCB in the geographic catchment area the Client or Applicant resides in.

8.501.6 Transferring Services Between Community Centered Boards:

1. When an individual enrolled in, or on the waiting list for, the State-SLS program moves to another CCB's catchment area, and wishes to transfer their State-SLS, the following procedure shall be followed:

    a. The originating CCB will contact the receiving CCB to inform them of the individual's desire to transfer.

    b. The originating CCB will send the State-SLS Individual Support Plan to the receiving CCB, where the receiving CCB will determine if appropriate State-SLS funding is available or if the individual will need to be placed on a waiting list. The receiving CCB's decision of service availability will be communicated in the following way:

        i. The receiving CCB will notify the individual seeking transfer of its decision by the individual's preferred method, no later than ten (10) business days from the date of the request; and

        ii. The receiving CCB will notify the originating CCB of its decision by U.S. Mail, phone call or email of its decision no later than ten (10) business days from the date of the request.

    c. The decision shall clearly state the outcome of the decision including:

        i. The basis of the decision; and

        ii. The contact information of the assigned Case Manager or waiting list manager.

    d. The originating CCB shall contact the individual requesting the transfer no more than 5 days from the date the decision was received to:

        i. Ensure the individual understands the decision; and

        ii. Support the individual in making a final decision about the transfer.

    e. If the transfer is approved, there shall be a transfer meeting in-person when possible, or by phone if geographic location or time does not permit, within in fifteen (15) business days of when the notification of service determination is sent out by the receiving CCB. The transfer meeting must include but is not limited to the transferring individual and the receiving case manager. Any additional attendees must be approved by the transferring individual.

    f. The receiving CCB must ensure that:

i. the transferring individual meets his or her primary contact of the receiving CCB.

ii. The individual is informed of the date when Services and Supports will be transferred, when Services and Supports will be available, and the length of time the Supports and Services will be available.

g. The receiving CCB case manager shall have an in-person face to face meeting with the Client to review and update the State-SLS Individual Support Plan, prior to the Supports and Services being authorized. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.).

8.501.7 WAITING LIST PROTOCOL

1. Persons determined eligible to receive services under the State SLS program, shall be eligible for placement on a waiting list for services when state funding is unavailable.

2. Waiting lists for persons eligible for the State SLS program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Operating Agency's procedures.

3. Persons determined eligible shall be placed on the waiting list for services in the Community Centered Board service area of residency.

   a. The date used to establish a person's placement on a waiting list shall be:

      i. The date on which an individual is determined eligible for the State SLS program through the DD Determination and the identification of need.

4. As funding becomes available in the State SLS program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list.

5. Individuals with no other State or Medicaid funded services or supports will be given priority for enrollment including individuals who lose Medicaid eligibility and lose Medicaid Waiver services.

6. Exceptions to these requirements shall be limited to:

   a. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered, and the emergency cannot be resolved in another way. Emergencies are defined as follows:

      i. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; or whose primary residence during the night is a public or private facility that provides temporary living accommodations; or any other unstable or non-permanent situation; or is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

ii. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

iii. Danger to Others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

iv. Danger to Self: a person's medical, psychiatric or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

v. Loss or Incapacitation of Primary Caregiver: a person's primary caregiver is no longer in the person's primary residence to provide care; or the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or the primary caregiver is age 65 years or older and continuing to provide care poses an imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.

7. Documentation demonstrating how the individual meets the emergency criteria shall be kept on file at the CCB and made available to the Department upon request.

8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (HCBS-CES)

8.503 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, transferring, and needing supervision to support behavior, medical needs and memory cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-CES waiver or a HCBS waiver service.

C. APPLICANT means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.

E. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community ~~-b~~B~~a~~ased Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the Department.

F. CLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community ~~-b~~B~~a~~ased Services (HCBS).

G. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community ~~-b~~B~~a~~sed Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

I. COST CONTAINMENT means limiting the cost of providing care in the community to 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 ~~-b~~B~~a~~sed Services, and Medicaid State Plan benefits including ~~long term~~long-term home health services and targeted case management.

J. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

K. CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when

included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single state Medicaid agency.

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and is defined as:

A mother, father, brother, sister,

Extended blood relatives such as grandparent, aunt, uncle, cousin,

An adoptive parent,

One or more individuals to whom legal custody of a person with a developmental disability has been given by a court,

A spouse or,

The Client's child.

Q. FISCAL MANAGEMENT SERVICE (FMS) means the entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual Client allocations for CDASS.

R. FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for long-term services and supports as determined by the Department

S. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long-t-Term Care instrument and medical verification on the Professional Medical Information Page to determine if the applicant or Client meets the institutional Level off Care (LOC).

T. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

U. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

V. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

W. INSTITUTION means a hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the state plan.

X. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately operated facility that provides health and habilitation services to a Client with developmental disabilities or related conditions.

Y. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse

Z. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

AA. 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 governed by the Colorado Medical License Act and the Colorado Nurse Practice Act.

BB. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

CC. MEDICAID ELIGIBLE means the applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

DD. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

EE. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

FF. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

GG. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in Home and Community Services for persons with Developmental Disabilities (HCBS-DD), HCBS- Supported Living Services (HCBS-SLS) and HCBS- Children's Extensive Supports (HBCS-CES) waivers.

HH. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to ~~verify the Client needs institutional Level of Care.~~certify the Applicant's or Client's need for long-term care.

JJ. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received program approval to provide HCBS-CES waiver services.

KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the Client received services according to the service plan and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

MM. SERVICE PLAN means the written document that specifies identified and needed services, regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules

NN. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

OO. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

PP. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

QQ. UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the Department to review the HCBS-CES waiver applications for determination of eligibility based on the additional targeting criteria.

RR. WAIVER SERVICE means optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

8.503.10 HCBS-CES WAIVER ADMINISTRATION

A. This section hereby incorporates the terms and provisions of the federally approved Home and Community-~~-b~~Based Services-Children's Extensive Support (HCBS-CES) waiver CO.4180.R03.00. To the extent that the terms of that federally approved waiver are inconsistent with the provisions of this section, the waiver will control

B. HCBS-CES waiver for Clients ages birth through seventeen years of age with Developmental Delays or disabilities is administered through the designated Operating Agency.

C. HCBS-CES waiver services shall be provided in accordance with the federally approved HCBS-CES waiver document and these rules and regulations.

D. HCBS-CES waiver services are available only to address needs identified in the Functional Needs Assessment and authorized in the Service Plan and when the service or Support is not available through the Medicaid State Plan, EPSDT, Natural Supports, or third party payment sources.

E. HCBS-CES waiver:

1. Shall not constitute an entitlement to services from either the Department or its agents;

2. Shall be subject to annual appropriations by the Colorado General Assembly;

3. Shall limit the utilization of the HCBS-CES waiver based on the federally approved capacity, Cost Containment, the maximum costs and the total appropriations; and,

4. May limit enrollment when utilization of the HCBS-CES waiver program is projected to exceed the spending authority.

8.503.20 GENERAL PROVISIONS

A. The following provisions apply to the HCBS – CES waiver:

1. HCBS-CES waiver services are provided as an alternative to ICF-IID services for an eligible Client to assist the Family to Support the Client in the home and community.

2. HCBS-CES waiver is waived from the requirements of Section 1902(a) (10) (b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the state of Colorado.

3. A Client enrolled in the HCBS-CES waiver shall be eligible for all other Medicaid services for which the Client qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-CES waiver. Services received through the HCBS-CES waiver may not duplicate services available through the Medicaid State Plan.

8.503.30 CLIENT ELIGIBILITY

A. To be eligible for the HCBS-CES waiver, an individual shall meet the target population criteria as follows:

1. Is unmarried and less than eighteen years of age,

2. Be determined to have a Developmental Disability which includes Developmental Delay if under five (5) years of age,

3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and Cost Containment limits of the HCBS-CES waiver,

4. Meet ICF-IID Level Of Care as determined by the Functional Needs Assessment,

5. Meet the Medicaid financial determination for ~~Long Term~~Long-term Care (LTC) eligibility as specified at Section 8.100 *et seq.* and,

6. Reside in an eligible HCBS-CES waiver setting as defined as the following:

a. With biological, adoptive parent(s), or legal Guardian,

b. In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement:

i. The case manager will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or Supports requested during the time the Client is not residing in the Family home. The case manager will submit the transition plan to the Department for approval prior to the start of services.

7. Be determined to meet the Federal Social Security Administration's definition of disability,

8. Be determined by the Department or it's agent to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:

a. The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically Age Appropriate and due to one or more of the following conditions:

i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a ~~life threatening~~life-threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six (6) months,

ii. A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six (6) months, or

iii. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

b. In the instance of an annual reassessment, the reassessment must demonstrate in the absence of the existing interventions or preventions provided through Medicaid that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criterion listed above.

B. The Client shall maintain eligibility by meeting the HCBS-CES waiver eligibility as set forth in Section 8.503 and the following:

1. Receives at least one (1) HCBS-CES waiver service each calendar month,

2. Is not simultaneously enrolled in any other HCBS waiver, and

3. Is not residing in a hospital, nursing facility, ICF-IID, other Institution or correctional facility.

8.503.40 HCBS-CES WAIVER SERVICES

A. The following services are available through the HCBS-CES waiver within the specific limitations as set forth in the federally approved HCBS-CES waiver:

1. Adaptive therapeutic recreational equipment and fees are services which assist a Client to recreate within the Client's community. These services include recreational equipment

that is adapted specific to the Client's disability and not those items that a typical age peer would commonly need as a recreation item.

a. The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.

b. Adaptive therapeutic recreational equipment may include adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a Client with a Developmental Disability.

c. A pass for admission to recreation centers for the Client only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.

d. Adaptive therapeutic recreation fees include those for water safety training.

e. The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. Entrance fees for zoos,

ii. Museums,

iii. Butterfly pavilion,

iv. Movie, theater, concerts,

v. Professional and minor league sporting events,

vi. Outdoors play structures,

vii. Batteries for recreational items; and,

viii. Passes for Family admission to recreation centers.

f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per Service Plan year.

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

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

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

c. Training or technical assistance for the Client, or where appropriate, the Family members, Guardians, ~~care-givers~~caregivers, advocates, or authorized representatives of the Client,

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

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

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

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

h. When the expected cost is to exceed two thousand five hundred (2,500) dollars per device three estimates shall be obtained and maintained in the case record.

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

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

    i. Purchase, training or maintenance of service animals,

    ii. Computers,

    iii. In home installed video monitoring equipment,

    iv. Medication reminders,

    v. Hearing aids,

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

    vii. Training, or adaptation directly related to a school or home educational goal or curriculum; or

    viii. Items considered as typical toys for children.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the Client or that enable the Client to function with greater independence in the home or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the

Department's procedures and the Department shall respond to exception requests within thirty (30) days of receipt.

3. Community connector services are intended to provide assistance to the Client to enable the Client to integrate into the Client's residential community and access naturally occurring resources. Community connector services shall:

   a. Support the abilities and skills necessary to enable the Client to access typical activities and functions of community life such as those chosen by the general population.

   b. Utilize the community as a learning environment to assist the Client to build relationships and Natural Supports in the Client's residential community.

   c. Be provided to a single Client in a variety of settings in which Clients interact with individuals without disabilities, and

   d. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.

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

   a. Hippotherapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Hippotherapy can be reimbursed only when:

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

      ii. The intervention is related to an identified medical or behavioral need; and

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

   b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

      i. Equine therapy,

      ii. Therapeutic riding; and,

      iii. Experimental treatments or therapies.

8.503.40.A.5. HOME ACCESSIBILITY ADAPTATIONS

8.503.40.A.5.a DEFINITIONS

Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the

Department to provide case management services for specific Home and Community-bBased Services waivers pursuant to Ssections 25.5-10-209.5 , ~~C.R.S.~~ and 25.5-6-106, C.R.S. and pursuant to a provider participation agreement with the state Department.

Case Manager means a person who provides case management services and meets all regulatory requirements for case managers.

The Division of Housing (DOH) is a division within the Colorado Department of Local Affairs that is responsible for approving Home Accessibility Adaptation PARs, oversight on the quality of Home Accessibility Adaptation projects, and inspecting Home Accessibility Adaptation projects, as described in these regulations

2. DOH oversight is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, all oversight functions shall be performed by the Department unless specifically allowed by the Participant or their guardian to be performed by DOH.

Home Accessibility Adaptations means the most cost-effective physical modifications, adaptations, or improvements in a Participant's existing home setting which, based on the Participant's medical condition or disability:

1. Are necessary to ensure the health and safety of the Participant, or

2. Enable the Participant to function with greater independence in the home, or

3. Prevent institutionalization or support the deinstitutionalization of the Participant.

Home Accessibility Adaptation Provider means a provider agency that meets all the standards for Home Accessibility Adaptation described in Section 8.503.A.5.e and is an enrolled Medicaid provider.

Person-Centered Planning means Home Accessibility Adaptations that are agreed upon through a process that is driven by the Participant and can include people chosen by the Participant, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations; and where the Participant is provided necessary information, support, and choice Participant to ensure that the Participant directs the process to the maximum extent possible.

8.503.40.A.5.b INCLUSIONS

8.503.40.A.5.b.i. Home Accessibility Adaptations may include, but are not limited to, the following:

a) Installing or building ramps;

b) Installing grab-bars or other Durable Medical Equipment (DME) if such installation cannot be performed by a DME supplier;

c) Widening or modification of doorways;

d). Modifying a of bathroom facility for the purposes of accessibility, health and safety, and independence in Activities of Daily Living;

e) Modifying a kitchen for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

d) Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies;

g) Installing stair lifts or vertical platform lifts;

h) Modifying an existing second exit or egress window to lead to an area of rescue for emergency purposes;

i) The modification of a second exit or egress window must be approved by the Department or DOH at any funding level as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the Participant.

i) Safety enhancing supports such as basic fences, strengthened windows, and door and window alerts.

8. 503.40.A.5.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of Section 8.503.40.A.5.

8. 503.40.A.5.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.

8. 503.40.A.5.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.

8. 503.40.A.5.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.

a) Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the Participant, or enable the Participant to function with greater independence in the home, if:

i) The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and

ii) Either:

1. There is an immediate risk to the Participant's health or safety, or

2. There has been a significant change in the Participant's needs since a previous Home Accessibility Adaptation.

b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule section 8.503.A.5.

8. 503.40.A.5.**c EXCEPTIONS AND RESTRICTIONS**

8. 503.40.A.5.c.i Home Accessibility Adaptations must be a direct benefit to the Participant and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.

8. 503.40.A.5.c.ii Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, are prohibited.

8. 503.40.A.5.c.iii Adaptations, improvements, or modifications as a part of new construction costs are prohibited.

a) Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.

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

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

ii) configure a bathroom to accommodate a wheelchair.

c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department procedures.

8. 503.40.A.5.c.iv The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.

8.503.40.A.5.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.

8.503.40.A.5.c.vi. Upgrades beyond what is the most cost-effective means of meeting the Participant's identified need, including, but not limited to, items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

8.503.40.A.5.c.vii. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

a) Roof repair,

b) Central air conditioning,

c) Air duct cleaning,

d) Whole house humidifiers,

e) Whole house air purifiers,

f) Installation and repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,

g) Monthly or ongoing home security monitoring fees,

h) Home furnishings of any type,

i) HOA fees.

8.503.40.A.5.c.viii. Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.

8.503.40.A.5.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.503.40.A.5.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the 2018 Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to Sect§24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8. 503.40.A.5.d CASE MANAGEMENT AGENCY RESPONSIBILITIES

8. 503.40.A.5.d.i. The Case Manager shall consider alternative funding sources to complete the Home Accessibility Adaptation. These alternatives considered and the reason they are not available shall be documented in the case record.

1) The Case Manager must confirm that the Participant is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding. Case Managers may request confirmation of a property owner's obligations through DOH.

8. 503.40.A.5.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval and confirmation of Home Accessibility Adaptation fund availability.

8. 503.40.A.5.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization Request form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5. Home Accessibility Adaptations submitted with improper documentation will not be approved.

2) The Case Manager and CMA are responsible for retaining and tracking all documentation related to a Participant's Home Accessibility Adaptation funding use and communicating that information to the Participant and Home Accessibility Adaptation providers. The Case Manager may request confirmation of a Participant's Home Accessibility Adaptation fund use from the Department or DOH.

3) The Case Manager shall discuss any potential plans to move to a different residence with the Participant or their guardian and advise them on the most prudent utilization of available funds.

8. 503.40.A.5.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1) An occupational or physical therapist (OT/PT) shall assess the Participant's needs and the therapeutic value of the requested Home Accessibility Adaptation. When an OT/PT with experience in Home Accessibility Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Accessibility Adaptation would contribute to a Participant's ability to remain in or return to his/her home, and how the Home Accessibility Adaptation would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

a) The evaluation must be performed in the home to be modified. If the Participant is unable to access the home to be modified without the modification, the OT/PT must evaluate the Participant and home separately and document why the Participant was not able to be evaluated in the home.

2) The evaluation may be provided by a home health agency or other qualified and approved OT/PT through the Medicaid Home Health benefit.

a) A Case Manager may initiate the OT/PT evaluation process before the Participant has been approved for

waiver services, as long as the Participant is Medicaid eligible.

b) A Case Manager may initiate the OT/PT evaluation process before the Participant physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

c) OT/PT evaluations performed by non-enrolled Medicaid providers may be accepted when an enrolled Medicaid provider is not available. A Case Manager must document the reason why an enrolled Medicaid provider is not available.

3) The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Participant's needs. The Case Manager shall document these alternatives and why they did not meet the Participant's needs in the Participant's case file.

8. 503.40.A.5.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:

1) The Case Manager shall assist the Participant in soliciting bids from at least two Home Accessibility Adaptation Providers for Home Accessibility Adaptations estimated to cost $2,500 or more.

2) The Case Manager must verify that the provider is an enrolled Home Accessibility Adaptation Provider for Home Accessibility Adaptations.

3) The bids for Home Accessibility Adaptations at all funding levels shall include a breakdown of the costs of the project and the following:

a) Description of the work to be completed.

b) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.

c) Estimate for building permits, if needed,

d) Estimated timeline for completing the project,

e) Name, address and telephone number of the Home Accessibility Adaptation Provider,

f) Signature, physical or digital, of the Home Accessibility Adaptation Provider,

g) Signature or other indication of approval, such as email approval, of the Participant or their guardian, that

indicates all aspects of the bid have been reviewed with them,

h) Signature, physical or digital, of the home-owner or property manager if the home is not owned by the Participant or their guardian.

4) Home Accessibility Adaptation Providers have a maximum of thirty (30) days to submit a bid for the Home Accessibility Adaptation project after the Case Manager has solicited the bid.

a) If the Case Manager has made three attempts to obtain a bid from a Home Accessibility Adaptation Provider and the provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

5) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.503.40.A.5 and the recommendations of the OT/PT evaluation.

a) If a Participant or home owner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

6) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.503.40.A.5.

8. 503.40.A.5.d.vi. If a property to be modified is not owned by the Participant or their guardian, the Case Manager shall obtain physical or digital, signatures from the home-owner or property manager on the submitted bids authorizing the specific modifications described therein.

1) Written consent of the home-owner or property manager is required for all projects that involve permanent installation within the Participant's residence or installation or modification of any equipment in a common or exterior area.

2) The authorization shall include confirmation that the home owner or property manager agrees that if the Participant vacates the property, the Participant may choose to either leave the modification in place or remove the modification, that the home owner or property manager may not hold any party responsible for removing all or part of a Home Accessibility Adaptation project, and that if the Participant chooses to remove the modification, the property must be left in equivalent or better than its pre-modified condition.

8. 503.40.A.5.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation,

the Department may hold the CMA financially liable for the increased cost.

8. 503.40.A.5.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR.

8. 503.40.A.5.e PROVIDER RESPONSIBILITIES

8. 503.40.A.5.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in Section 8.500.98.

8. 503.40.A.5.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the Home Accessibility Adaptation services will be performed, if required by that city or county.

8. 503.40.A.5.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

1) If any changes to the approved scope of work are made without DOH or Department authorization, the cost of those changes will not be reimbursed.

2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

8. 503.40.A.5.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's expense.

1) The Provider shall give the Participant or their guardian all manufacturer's or seller's warranties on completion of work.

8. 503.40.A.5.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8. 503.40.A.5.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any

other person as designated by the Department. Home Accessibility Adaptation projects may be inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. Participants must provide access for inspections.

1) DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion for sampled projects, or receipt of a Participant's reasonable request.

2) DOH shall produce a written inspection report within the time frame agreed upon in the Home Accessibility Adaptations work plan that notes the Participant's specific complaints. The inspection report shall be sent to the Participant, Case Manager, and provider.

3) Home Accessibility Adaptation providers must repair or correct any noted deficiencies within twenty (20) days or the time required by the inspection, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

8. 503.40.A.5.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis for non-payment or recovery of payment by the Department.

1) Volunteer work on a Home Accessibility Adaptation project approved by the Department shall be completed under the supervision of the Home Accessibility Adaptation Provider as stated on the bid.

a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5.

b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5.

8. 503.40.A.5.f REIMBURSEMENT

8. 503.40.A.5.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments.

8. 503.40.A.5.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8. 503.40.A.5.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation to DOH:

1) Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2) Required permits;

3) One year written warranty on materials and labor; and

4) Documentation in the Participant's file that the Home Accessibility Adaptation has been completed satisfactorily through:

a) Receipt of the inspection report approving work from the state, county, or local building, plumbing, or electrical inspector;

b) Approval by the Participant, guardian, representative, or other designee;

c) Approval by the home owner or property manager;

d) A final on-site inspection report by DOH or its designated inspector; or

e) DOH acceptance of photographs taken both before and after the Home Accessibility Adaptation.

8. 503.40.A.5.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8. 503.40.A.5.f.v. The Home Accessibility Adaptation Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.

1) All required repairs noted on inspections shall be completed before the Home Accessibility Adaptation Provider submits a final claim for reimbursement.

2) If a Home Accessibility Adaptation Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the provider during an inspection. The provider shall only be reimbursed for the value of the work completed satisfactorily.

a) A Home Accessibility Adaptation Provider may request DOH perform one (1) reconsideration of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the provider's expense.

8. 503.40.A.5.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.

1) Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 7 day deadline and be supported by documentation, including Participant notification.

2) The Home Accessibility Adaptation reimbursement reduced pursuant to this subsection shall be considered part of the Participant's remaining funds.

8. 503.40.A.5.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

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

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

i. This assistance may take the form of hands-on assistance by actually performing a task for the Client or cueing to prompt the Client to perform a task.

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

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

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

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

1). When such Support is incidental to the habilitative services being provided,

2). To increase independence of the Client,

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

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

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

a. Massage therapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Massage therapy is reimbursed only when:

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

ii. The intervention is related to an identified medical or behavioral need; and

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

b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

i. Acupuncture,

ii. Chiropractic care, and,

iii. Experimental treatments or therapies.

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

a. Movement therapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need and Movement therapy can be reimbursed only when:

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

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

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

b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

i. Fitness training (personal trainer),

ii. Warm water therapy,

iii. Experimental treatments or therapies, and

iv. Yoga.

9. Parent education provides unique opportunities for parents or other care givers to learn how to Support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. Parent education includes:

a. Consultation and direct service costs for training parents and other caregivers in techniques to assist in caring for the Client's needs, including sign language training,

b. Special resource materials,

c. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the Client's disability, and

d. Cost of membership to parent Support or information organizations and publications designed for parents of children with disabilities.

e. The maximum service limit for parent education is one thousand (1,000) units per Service Plan year.

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

i. Transportation,

ii. Lodging,

iii. Food, and

iv. Membership to any political organizations or any organization involved in lobby activities.

10. Respite is provided to Clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the Client.

a. Respite may be provided:

i. In the Client's home or a private residence,

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

iii. In the community.

b. Respite is to be provided in an Age Appropriate manner.

i. A Client eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children.

c. When the cost of care during the time the parents works is more for an eligible Client, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care.

d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible Client when supervision is needed so the primary caretaker can take the Client to receive a state plan benefit or a HCBS-CES waiver service.

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

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

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

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

iv. Group: the Client receives care along with other individuals, who may or may not have a disability. The total cost of group within a twenty-four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:

1) Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling.

f. Federal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to Section 8.602 by the state that is not a private residence.

g. The total amount of respite provided in one Service Plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The Department may approve a higher amount based on a need due to the Client's age, disability or unique Family circumstances.

h. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or other services not covered by the HCBS-CES waiver.

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

j. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a Client. Therefore, additional respite units beyond the service limit will not be approved for Clients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.

11. Specialized medical equipment and supplies include devices, controls, or appliances that are required due to the Client's disability and that enable the Client to increase the Client's ability to perform Activities of Daily Living or to safely remain in the home and community. Specialized Medical Equipment and Supplies include:

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

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

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

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

i. Items that are not of direct medical or remedial benefit to the Client, vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items and wipes for any purpose other than incontinence.

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

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

b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include:

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

ii. Purchase or lease of a vehicle, and

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

c. The total cost of Home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five

(5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the Client, to enable the Client to function with greater independence in the home, or to decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure Cost Effectiveness, prudent purchases and no unnecessary duplication.

13. Youth Day

a. Youth day service is the care and supervision of Clients ages 12 through 17 while the primary caregiver works, volunteers, or seeks employment.

b. Youth day service may be provided in the residence of the Client, youth day service provider, or in the community.

c. Youth day service shall be provided according to an individual or group rate as defined below:

i. Individual: The Client receives youth day services with a staff ratio of 1:1, billed at a 15-minute unit. There are no other youth in the setting also receiving youth day service, respite or third-party supervision.

ii. Group: The Client receives supervision in a group setting with other individuals who may or may not have a disability. Reimbursement is limited to the Client.

d. Limitations:

i. This service is limited to Clients ages 12 through 17.

ii. This service may not substitute for or supplant special education and related services included in a Client's Individualized Education Plan (IEP) developed under Part B of the Individuals with Disabilities Education Act, 20 U.S.cC. § 1400 (2011). This includes after school care provided through any education system and funded through any education system for any student.

iii. This service may not be used to cover any portion of the cost of camp.

iv. This service is limited to ten (10) hours per calendar day.

8.503.50 SERVICE PLAN.

The case management agency shall complete a service plan for each ~~client~~Client enrolled in the HCBS-CES waiver in accordance with Section 8.519.11.B.2.

8.503.60 WAITING LIST PROTOCOL

A. When the HCBS-CES waiver reaches capacity for enrollment, a Client determined eligible for HCBS-CES waiver benefits shall be placed on a statewide waiting list in accordance with these rules and the Department's procedures.

1. The Community Centered Board shall determine if an Applicant has Developmental Delay if under age five (5), or Developmental Disability if over age five (5) , prior to submitting the HCBS-CES waiver application to the Department or its agent. Only a Client who is determined to have a Developmental Delay or Developmental Disability may apply for HCBS-CES waiver.

2. In the event a Client who has been determined to have a Developmental Delay is placed on the wait list prior to age five (5), and that Client turns five (5) while on the HCBS-CES waiver wait list, a determination of Developmental Disability must be completed in order for the Client to remain on the wait list.

3. The Case Management Agency shall complete the Functional Needs Assessment, as defined in Department rules, to determine the Client's Level of Care.

4. The Case Management Agency shall complete the HCBS-CES waiver application with the participation of the Family. The completed application and a copy of the Functional Needs Assessment that determines the Client meets the ICF-IID Level Of Care shall be submitted to the Department or its agent within fourteen (14) calendar days of parent signature.

5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the Department or its agent.

6. The Department or its agent shall review the HCBS-CES waiver application. In the event the Department or its agent needs additional information; the Case Management Agency shall respond within two (2) business days of request.

7. Any Client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide waiting list in the order in which the Department or its agent received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the Client's appeal rights in accordance with Section 8.057.

8. The Case Management Agency will create or update the consumer record to reflect the Client is waiting for the HCBS-CES waiver with the waiting list date as determined by the Department or its agent.

8.503.70 ENROLLMENT

A. When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.

1. The Case Management Agency shall complete the HCBS-CES waiver application and the Functional Needs Assessment in the Family home with the participation of the Family. The completed application and a copy of the Functional Needs Assessment shall be submitted to the Department or its agent within thirty (30) days of the authorized initial enrollment date.

a. If it has been less than six (6) months since the review to determine waiting list eligibility by the ~~Utilization Review Contractor~~URC and there has been no change in the Client's condition, the Case Management Agency shall complete the Functional Needs Assessment and the parent may submit a letter to the Case

Management Agency in lieu of the HCBS-CES waiver application stating there has been no change.

b. If there has been any change in the Client's condition the Case Management Agency shall complete a Functional Needs Assessment and the HCBS-CES waiver application which shall be submitted to the Department or its agent.

2. Services and Supports shall be implemented pursuant to the Service Plan within 90 days of the parent or Guardian signature.

3. All continued stay review enrollments shall be completed and submitted to the Department or its agent at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

8.503.80 CLIENT RESPONSIBILITIES

A. The parent or legal Guardian of a Client is responsible to assist in the enrollment of the Client and cooperate in the provision of services. Failure to do so shall result in the Client's termination from the HCBS-CES waiver. The parent or legal Guardian shall:

1. Provide accurate information regarding the Client's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions;

2. Cooperate with providers and Case Management Agency requirements for the HCBS-CES waiver enrollment process, continued stay review process and provision of services;

3. Cooperate with the local Department of Human Services in the determination of financial eligibility;

4. Complete the HCBS-CES waiver application with fifteen (15) calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a continued stay review, at least thirty (30) days prior to the end of the current certification period;

5. Complete the Service Plan within thirty (30) calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the Department or its agent.

6. Notify the case manager within thirty (30) days after changes:

a. In the Client's Support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF-IID placements;

b. That may affect Medicaid financial eligibility such as prompt report of changes in income or resources;

c. When the Client has not received an HCBS-CES waiver service for one calendar month;

d. In the Client's care needs; and,

e. In the receipt of any HCBS-CES waiver services.

8.503.90 PROVIDER REQUIREMENTS

A. A private for profit or not for profit agency or government agency shall ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver and shall:

1. Conform to all state established standards for the specific services they provide under HCBS-CES waiver,

2. Maintain program approval and certification from the Department,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in Section 8.130,

4. Discontinue HCBS-CES waiver services to a Client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide HCBS-CES waiver services,

5. Have written policies governing access to duplication and dissemination of information from the Client's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S.,

6. When applicable, maintain the required licenses and certifications from the Colorado Department of Public Health and Environment, and

7. Maintain Client records to substantiate claims for reimbursement according to Medicaid standards.

B. HCBS-CES waiver service providers shall comply with:

1. All applicable provisions of Article 10 of Title 25.5, C.R.S. and all rules and regulations as set forth in Section 8.600,

2. All federal and state program reviews or financial audit of HCBS-CES waiver services,

3. The Department’s on-site certification reviews for the purpose of program approval, on-going program monitoring or financial and program audits,

4. Requests from the County Departments of Human Services to access records of Clients and to provide necessary Client information to determine and re-determine Medicaid financial eligibility,

5. Requests by the Department to collect, review and maintain individual or agency information on the HCBS-CES waiver, and

6. Requests by the Case Management Agency to monitor service delivery through targeted case management activities.

8.503.100 TERMINATION OR DENIAL OF HCBS-CES MEDICAID PROVIDER AGREEMENTS

A. The Department may deny or terminate an HCBS-CES waiver Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at Section 8.076.

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-CES waiver services.

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior Client notification.

5. The provider fails to comply with requirements for submission of claims under Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with procedures at Section8.076.

8.503.110 ORGANIZED HEALTH CARE DELIVERY SYSTEM

A. The Organized Health Care Delivery System (OHCDS) for HCBS-CES waiver is the Community Centered Board as designated by the Department in accordance with Section 25.5 -10-209, C.R.S..

1. The OHCDS is the Medicaid provider of record for a Client whose services are delivered through the OHCDS.

2. The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS-CES waiver services according to the current federally approved waiver.

3. The OHCDS may contract or employ for delivery of HCBS-CES waiver services.

4. The OCHDS shall:

   a. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver,

   b. Ensure that services are delivered according to the HCBS-CES waiver definitions and as identified in the Client's Service Plan,

   c. Ensure the contractor maintains sufficient documentation to Support the claims submitted, and

   d. Monitor the health and safety of HCBS-CES waiver Clients receiving services from a subcontractor.

5. The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

   a. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

   b. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

c. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to Clients

d. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and the Department's procedures:

i. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

e. Collect and maintain the data used to develop provider rates and ensure data includes costs for the services to address the Client's needs, that are allowable activities within the HCBS-CES waiver service definition and that Supports the established rate, and

f. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency and Centers for Medicare and Medicaid Services (CMS).

g. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.503.120 PRIOR AUTHORIZATION REQUESTS

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14.

8.503.130 RETROSPECTIVE REVIEW PROCESS

A. Services provided to a Client are subject to a Retrospective Review by the Department or its agent. This Retrospective Review shall ensure that services:

1. Identified in the Service Plan is based on the Client's identified needs as stated in the Functional Needs Assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a Client are in accordance with the Service Plan, and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-CES waiver.

B. The Case Management Agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department or its agent when areas of non-compliance are identified in the Retrospective Review.

C. The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

D. When the provider has received reimbursement for services and the review by the Department or its agent identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of the provider agreement.

8.503.140 PROVIDER REIMBURSEMENT

A. Providers shall submit claims directly to the Department's fiscal agent through the Medicaid Management Information System (MMIS) or through a qualified billing agent enrolled with the Department's fiscal agent.

1. Provider claims for reimbursement shall be made only when the following conditions are met:

a. Services are provided by a qualified provider as specified in the federally approved HCBS-CES waiver,

b. Services have been prior authorized,

c. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the Client's Service Plan, and

d. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the Service Plan and in accordance with the service definition.

2. Provider claims for reimbursement shall be subject to review by the Department or its agent. This review may be completed before or after payment has been made to the provider.

3. When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department or its agent.

4. When the provider has received reimbursement for services and the review by the Department or its agent identifies that the service delivered, or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.503.150 CLIENT RIGHTS

A. Client rights should be in accordance with Sections 25.5-10-218 through 231, C.R.S.

8.503.160 APPEAL RIGHTS

Case Management Agencies shall meet the requirements set forth at Section 8.519.22

8.503.160.A The CCB shall provide the long-term care notice of action form to the applicant and Client's parent or legal guardian within eleven (11) business days regarding the Client's appeal rights in accordance with Section 8.057 *et seq.* when:

1. The Client or applicant is determined not to have a developmental delay or developmental disability,

2. The Client or applicant is determined eligible or ineligible for Medicaid LTSS,

3. The Client or applicant is determined eligible or ineligible for placement on a waiting list for Medicaid LTSS,

4. An Adverse Action occurs that affects the Client's or applicant's HCBS-CES waiver enrollment status through termination or suspension,

8.503.160.B The CCB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CCB has made a denial or adverse action against a Client or applicant.

8.503.160.C The CCB shall notify the Case Management Agency in the ~~client~~Client's service plan within one (1) business day of the adverse action.

8.503.160.D The CCB shall notify the County Department of Human Services income maintenance technician within one (1) business day of an Adverse Action that affects Medicaid financial eligibility.

8.503.160.E The CCB shall inform the applicant's or Client's parent or legal guardian of an adverse action if the applicant or Client is determined ineligible and the following:

1. The Client or applicant, parent or legal guardian fails to submit the Medicaid financial application for LTC to the financial eligibility site within thirty (30) days of LTC referral,

2. A Client, parent or legal guardian fails to submit financial information for re-determination for LTC to the financial eligibility site within the required re-determination timeframe,

3. The County Income Maintenance Technician has determined the Client no longer meets financial eligibility criteria as set forth in Section 8.100,

4. The Client cannot be served safely within the cost containment as identified in the HCBS-CES waiver,

5. The Client requires twenty-four (24) hour supports provided through Medicaid state plan,

6. The resulting total cost of services provided to the Client, including Targeted Case Management, home health and HCBS-CES waiver services, exceeds the cost containment as identified in the HCBS-CES waiver,

7. The Client enters an institution for treatment with duration that continues for more than thirty (30) days,

8. The Client is detained or resides in a correctional facility, and

9. The Client enters an institute for mental illness with a duration that continues for more than thirty (30) days.

8.503.170 QUALITY ASSURANCE

A. The monitoring of HCBS-CES waiver services and the health and well-being of service recipients shall be the responsibility of the Department or its agent.

1. The Department or its agent may conduct reviews of each agency providing HCBS-CES waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department. The review will apply rules and standards developed for programs serving Clients with developmental disabilities.

2. The provider agency shall maintain or cause to be maintained for six (6) years a complete file of all records, documents, communications, and other materials which

pertain to the operation of the HCBS-CES waiver or the delivery of services under the HCBS-CES waiver. The Department shall have access to these records at any reasonable time.

3. The Department may deny or terminate the Medicaid provider agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Department within the prescribed period of time.

8.504 HOME AND COMMUNITY- -BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESS WAIVER

8.504.05 Legal Basis

The Home and Community- -bBased Services for Children with Life Limiting Illness program (HCBS-CLLI) in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CLLI program is also authorized under state law at ~~C.R.S. §~~Section 25.5-5-305 ~~-~~C.R.S.~~et seq. – as amended.~~

8.504.1 DEFINITIONS

A. Assessment means a comprehensive evaluation with the individual 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 individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved assessment tool to complete assessments.

B. Bereavement Counseling means counseling provided to the ~~client~~Client and/or family members in order to guide and help them cope with the ~~client~~Client's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the ~~client~~Client and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.

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

D. Continued Stay Review (CSR) means a reassessment by the Single Entry Point case manager to determine the ~~client~~Client's continued eligibility and functional level of care.

E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital.

F. Curative Treatment means medical care or active treatment of a medical condition seeking to affect a cure.

G. Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the ~~client~~Client to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

H. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for ~~long term~~long-term services and supports; an individual's need for referral to

other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

I. Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood at age 19.

J. Massage Therapy means the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.

K. Palliative/Supportive Care is a specific program offered by a licensed health care facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care is specialized medical care for people with life limiting illnesses. This type of care is focused on providing ~~client~~Clients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the ~~client~~Client and the family. Palliative care is appropriate at any age (18 and under for this waiver) and at any stage in a life limiting illness and can be provided together with curative treatment. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of this waiver, Palliative Care includes Care Coordination and Pain and Symptom Management.

1. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the ~~client~~Client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the ~~client~~Client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a seamless system of care. Care Coordination does not include utilization management, that is review and authorization of service requests, level of care determinations, and waiver enrollment, provided by the case manager at the Single Entry Point.

2. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the ~~client~~Client's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

L. Prior Authorization Request (PAR) means the Department's prescribed form to authorize services.

M. Professional Medical Information Page (PMIP) ~~means the medical information signed by a licensed medical professional used as a component of the Assessment to determine the client~~Client~~'s need for institutional care.~~ means the medical information form signed by a licensed medical professional used to verify the Client needs institutional Level of Care

N. Respite Care means services provided to an eligible ~~client~~Client who is unable to care for himself/herself on a short-term basis because of the absence or the need for relief of those

persons normally providing care. Respite Care may be provided through different levels of care depending upon the needs of the ~~client~~Client. Respite care may be provided in the ~~client~~Client's residence, in the community, or in an approved respite center location.

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

P. Therapeutic Life Limiting Illness Support means grief/loss or anticipatory grief counseling that assist the ~~client~~Client and family to decrease emotional suffering due to the ~~client~~Client's health status, to decrease feelings of isolation or to cope with the ~~client~~Client's life limiting diagnosis. Support is intended to help the child and family in the disease process. Support is provided to the ~~client~~Client to decrease emotional suffering due to health status and develop coping skills. Support is provided to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the ~~client~~Client, and impending death of a child. Support is provided to the ~~client~~Client and/or family members in order to guide and help them cope with the ~~client~~Client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Support will include but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the family with community resources such as funding or transportation.

Q. Utilization Review means approving or denying admission or continued stay in the waiver based on level of care needs, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures or settings.

8.504.2 BENEFITS

8.504.2.A. Home and Community-~~-~~bBased Services under the Children with Life Limiting Illness Waiver (HCBS-CLLI) benefits shall be provided within Cost Containment.

8.504.2.B. Therapeutic Life Limiting Illness Support may be provided in individual or group setting.

1. Therapeutic Life Limiting Illness Support shall only be a benefit if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

2. Therapeutic Life Limiting Illness Support is limited to the ~~client~~Client's assessed need up to a maximum of 98 hours per annual certification period.

8.504.2.C. Bereavement Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

1. Bereavement Counseling is limited to the ~~client~~Client's assessed need and is only billable one time.

2. Bereavement Counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

8.504.2.D. Expressive Therapy may be provided in an individual or group setting.

1. Expressive Therapy is limited to the ~~client~~Client's assessed need up to a maximum of 39 hours per annual certification period.

8.504.2.E. Massage Therapy shall be provided in an individual setting.

1. Massage Therapy shall only be used for the treatment of conditions or symptoms related to the ~~client~~Client's illness.

2. Massage Therapy shall be limited to the ~~client~~Client's assessed need up to a maximum of 24 hours per annual certification period.

8.504.2.F. Respite Care shall be provided in the home, in the community, or in an approved respite center location of an eligible ~~client~~Client on a short term basis, not to exceed 30 days per annual certification as determined by the Department approved Assessment. Respite Care shall not be provided at the same time as state plan Home Health or Palliative/Supportive Care services.

1. Respite Care services include any of the following in any combination necessary according to the Support Planning services:

a. Skilled nursing services;

b. Home health aide services; or

c. Personal care services

8.504.2.G. Palliative/Supportive Care shall not require a nine month terminal prognosis for the ~~client~~Client and includes:

1. Pain and Symptom Management; and

2. Care Coordination

8.504.2.H. HCBS-CLLI ~~client~~Clients are eligible for all other Medicaid state plan benefits, including Hospice and Home Health.

8.504.3 NON-BENEFIT

8.504.3.A. Case Management is not a benefit of the HCBS-CLLI waiver. The Single Entry Point (SEP) provides case management services as an administrative activity.

8.504.4 CLIENT ELIGIBILITY

8.504.4.A. An eligible ~~client~~Client shall:

1. Be financially eligible.

2. Be at risk of institutionalization into a hospital as determined by the SEP case manager using the Department approved assessment tool.

3. Meet the target population criteria as follows:

a. Have a life-limiting diagnosis, as certified by a physician on the Department prescribed form, and

b. Have not yet reached 19 years of age.

8.504.4.B A ~~client~~Client shall receive at least one HCBS-CLLI waiver benefit per month to maintain enrollment in the waiver.

1. A ~~client~~Client who has not received at least one HCBS-CLLI waiver benefit during a month shall be discontinued from the waiver.

2. Case Management does not satisfy the requirement to receive at least one benefit per month on the HCBS-CLLI waiver.

8.504.5 WAIT LIST

8.504.5.A. The number of ~~client~~Clients who may be served through the waiver at any one time during a year shall be limited by the federally approved HCBS-CLLI waiver document.

8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-CLLI waiver, who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a wait list maintained by the Department.

8.504.5.C. The SEP case manager shall ensure the applicant meets all criteria as set forth in Section 8.504.4.A prior to notifying the Department to place the applicant on the wait list.

8.504.5.D. The SEP case manager shall enter the ~~client~~Client's Assessment and Professional Medical Information Page data in the Benefits Utilization System (BUS) and notify the Department by sending the ~~client~~Client's enrollment information, utilizing the Department's approved form, to the program administrator.

8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish the order of an applicant's place on the wait list.

8.504.5.F. Within five working days of notification from the Department that an opening for the HCBS-CLLI waiver is available, the SEP case manager shall:

1. Reassess the applicant for functional level of care using the Department approved assessment tool if the date of the last Assessment is more than six months old.

2. Update the existing Department approved assessment tool data if the date is less than six months old.

3. Reassess for the target population criteria.

4. Notify the Department of the applicant's eligibility status.

8.504.6 PROVIDER ELIGIBILITY

8.504.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CLLI waiver, enter into an agreement with the Department. Providers must comply with the requirements of ~~10 CCR 2505-10,~~ Section 8.130.

8.504.6.B. Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure regulations.

8.504.6.C. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

8.504.6.D. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall be one of the following:

1. Licensed Clinical Social Worker (LCSW)

2. Licensed Professional Counselor (LPC)

3. Licensed Social Worker (LSW)

4. Licensed Independent Social Worker (LISW)

5. Licensed Psychologist; or

6. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice agency.

8.504.6.E. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

1. Individuals providing Expressive Therapy delivering art or play therapy services shall meet the requirements for individuals providing Therapeutic Life Limiting Illness Support services and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent ~~client~~Clients.

2. Individuals providing Expressive Therapy delivering music therapy services shall hold a Bachelor's, Master's or Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists, and have at least one year of experience in the provision of music therapy to pediatric/adolescent ~~client~~Clients.

8.504.6.F. Massage Therapy providers shall have an approved registration and be in good standing with the Colorado Office of Massage Therapy Registration.

8.504.6.G. Individuals providing Palliative/Supportive Care services shall be employed by or working under a formal contract with a qualified Medicaid hospice or home health agency.

8.504.6.H. Individuals providing Respite services shall be employed by a qualified Medicaid home health, hospice or personal care agency.

8.504.7 PROVIDER RESPONSIBILITIES

8.504.7.A. HCBS-CLLI providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining and terminating employees.

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to S~~s~~ection 19-3-307 C.R.S~~. (2016)~~.

8.504.7.B. HCBS-CLLI providers shall:

1. Ensure a ~~client~~Client is not discontinued or refused services unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure ~~client~~Client records and documentation of services are made available at the request of the case manager.

3. Ensure that adequate records are maintained.

a. ~~Client~~Client records shall contain:

i. Name, address, phone number and other identifying information for the ~~client~~Client and the ~~client~~Client's parent(s) and/or legal guardian(s).

ii. Name, address and phone number of the SEP and the Case Manager.

iii. Name, address and phone number of the ~~client~~Client's primary physician.

iv. Special health needs or conditions of the ~~client~~Client.

v. Documentation of the specific services provided which includes:

1. Name of individual provider.

2. The location for the delivery of services.

3. Units of service.

4. The date, month and year of services and, if applicable, the beginning and ending time of day.

5. Documentation of any changes in the ~~client~~Client's condition or needs, as well as documentation of action taken as a result of the changes.

6. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.02.

7. Documentation of communication with the ~~client~~Client's SEP case manager.

8. Documentation of communication/coordination with other providers.

b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.504.7.A.

v. A copy of the employee's job description.

4. Ensure all care provided is coordinated with any other services the ~~client~~Client is receiving.

8.504.8 PRIOR AUTHORIZATION REQUESTS

8.504.8.A. The SEP case manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CLLI waiver.

8.504.8.B. All units of service requested shall be listed on the Support Planning form.

8.504.8.C. The first date for which services may be authorized is the latest date of the following:

1. The financial eligibility start date, as determined by the financial eligibility site.

2. The assigned start date on the certification page of the Department approved assessment tool.

3. The date, on which the ~~client~~Client's parent(s) and/or legal guardian signs the Support Planning form or Intake form, as prescribed by the Department, agreeing to receive services.

8.504.8.D. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Department approved assessment tool.

8.504.8.E. The SEP case manager shall submit a revised PAR if a change in the Support Planning results in a change in services.

8.504.8.F. The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.

8.504.8.G. Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.

~~8.504.8.H. A revised PAR shall not be submitted if services on the Support Planning document are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness~~.

8.504.8.H~~I~~. If services are decreased without the ~~client~~Client's parent(s) and/or legal guardian agreement, the SEP case manager shall notify the ~~client~~Client's parent(s) and/or legal guardian of the adverse action and appeal rights using the LTC 803 form in accordance with the 10 day advance notice period.

8.504.9 REIMBURSEMENT

8.504.9.A. Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

8.505 INCREASE OF THE REIMBURSEMENT RATE RESERVED FOR COMPENSATION OF DIRECT SUPPORT PROFESSIONALS

8.505.1 DEFINITIONS

Definitions below only apply to Section 8.505.

A. Compensation means any form of monetary payment, including bonuses, employer-paid health and other insurance programs, paid time off, payroll taxes that are proportionate to the increase in compensation, and all other fixed and variable benefits conferred on or received by all direct support professionals providing services as enumerated below.

B. Direct Support Professional means a worker who assists or supervises a worker to assist a person with intellectual and developmental disabilities to lead a fulfilling life in the community through a diverse range of services, including helping the person get ready in the morning, take medication, go to work or find work, and participate in social activities. Direct Support Professional includes all workers categorized as program direct support professionals and excludes workers categorized as administrative, as defined in standards established by the financial accounting standards board.

C. Direct Benefit means compensation that is directly conferred onto a direct support professional for their sole benefit and does not include direct benefits to the employing or contracting service agency which may have an indirect benefit to the direct support professional.

D. Plan of Correction means a formal, written response from a employing or contracting service agency to the Department on identified areas of non-compliance with requirements listed at Section 25.5-6-406, C.R.S. or ~~10 CCR 2505-10,~~ Section 8.505.

E. Payroll tax means taxes that are paid or withheld by the employer on the employee's behalf such as Social Security tax, Medicare tax, and Medicare surtax.

8.505.2 REIMBURSEMENT RATE INCREASE

A. Effective March 1, 2019, the Department increased reimbursement rates by six and a half percent which is to be reserved for compensation to direct support professionals above the rate of compensation that the direct support professionals received as of June 30, 2018. The six and a half percent rate increase must be used as a direct benefit for the direct support professional within 60 days from the close of the State Fiscal Year. The following services delivered through Home and Community ~~-~~ b~~B~~ased Waivers for Persons with Developmental Disabilities, Supported Living Services, and Children's Extensive Supports will receive the six and half percent increase to reimbursement rates:

1. Group Residential Services and Supports;

2. Individual Residential Services and Supports;

3. Specialized Habilitation;

4. Respite;

5. Homemaker Basic;

6. Homemaker Enhanced;

7. Personal Care;

8. Prevocational Services;

9. Behavioral Line Staff;

10. Community Connector;

11. Supported Community Connections;

12. Mentorship;

13. Supported Employment- Job Development; And

14. Supported Employment- Job Coaching.

B. Funding from the reimbursement rate increase may not be used for the following:

1. Executive Salaries

2. Administrative Expenses

3. Human Resource Expenses

4. Information Technology

5. Oversight Expenses

6. Business Management Expenses

7. General Record Keeping Expenses

8. Budget and Finance Expenses

9. Workers' Compensation Insurance

10. Contract Staffing Agency Expenses

11. Employee Appreciation Events

12. Gifts

13. Activities not identifiable to a single program.

8.505.3 REPORTING REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONAL RATE INCREASE

A. On or before December 31, 2019, and two (2) years thereafter, employing or contracting service agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-406, C.R.S. were used, including information about increased compensation for all Direct Support Professionals, how the employing or contracting service agency maintained the increase, and how the employing or contracting service agency stabilized the direct support professional workforce.

1. The employing or contracting service agencies must report to the Department, in the manner prescribed by the Department, by December 31 of each year.

2. The Department has ongoing discretion to request information from service agencies demonstrating how they maintained increases in compensation for Direct Support Professionals beyond the reporting period.

3. Failure to provide adequate and timely reports may result in recoupment of the funds.

8.505.4 AUDITING REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONAL RATE INCREASE FOR COMPENSATION

A. Each employing or contracted service agency shall keep true and accurate work records to support and demonstrate use of the funds. Such records shall be retained for a period of not less than three (3) years and shall be open to inspection by the Department and are made available to be copied by the Department or its authorized representatives at any reasonable time and as often as may be necessary.

B. Employing or contracting service agencies shall submit to the Department upon request, all records showing that the funds were used as a direct benefit for Direct Support Professionals, including but not limited to:

1. Federal Employment Forms

   a. W2's -Wage and Tax Statement

   b. W3 -Transmittal of Wage and Tax Statement

   c. 941's -Employer's Quarterly Federal Tax Return

   d. 940 -Employer's Annual Federal Tax Return

2. State Employment Forms

   a. UITR 1's – State Unemployment Insurance Tax Report

   b. UITR 1A's - State Unemployment Insurance Tax Report Wage List

3. Business/Corporate Tax Returns

4. Independent Contractor Forms

   a. 1099's- Miscellaneous Income

   b. 1096 - Annual Summary and Transmittal of U.S. Information Returns

5. Payroll Records

   a. Payroll Detail

   b. Payroll Summary

6. Accounting Records

   a. Chart of Accounts

   b. General Ledger

c. Profit & Loss Statements

d. Check Register

7. Bank Statements

8. Timesheets

9. Benefits Records

a. Health Insurance Records

b. Other Insurance Records

c. Paid Time Off Records

C. In the event that a Direct Support Professional was hired after June 30, 2018, the employing or contracting service agency shall use the lowest compensation paid to a Direct Support Professional of similar functions and duties as of June 30th, 2018. This is the base rate that the increased compensation will be applied to.

D. If the Department determines that the employing or contracting service agency did not use the increased funding as a direct benefit to the Direct Support Professional, within one year after the close of each reporting period, the Department shall notify the service agency in writing of the Department's intention to recoup funds. The service agency has forty-five (45) days after issuance of the notice of the determination to complete any of the following actions:

1. challenge the determination of the Department;

2. provide additional information to the Department demonstrating compliance;

3. submit a Plan of Correction to the Department.

E. When the Department determines that an employing or contracting service agency is not in compliance, a Plan of Correction shall be developed, upon written notification by the Department. A Plan of Correction shall include, but not be limited to:

1. A detailed description of actions to be taken to resolve issues and supporting documentation demonstrating completion.

2. A detailed timeframe specifying the actions to be taken.

3. Employee(s) responsible for implementing the actions.

4. The implementation timeframes and date(s) for completion.

F. The employing or contracting service agency must submit the Plan of Correction to the Department within forty-five (45) business days of the issuance of a written request from the Department. The employing or contracting service agency must notify the Department in writing, within five (5) business days of the receipt of the written request from the Department, if it will not be able to submit the Plan of Correction by the due date. The employing or contracting service agency must explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the employing or contracting service agency’s compliance.

G. Upon receipt of the Plan of Correction, the Department will accept, request modifications, or reject the proposed Plan of Correction. Modifications or rejections will be accompanied by a written explanation. If a Plan of Correction is rejected, the employing or contracting service agency must resubmit a new Plan of Correction along with any requested documentation to the Department for review within five (5) business days of notification.

H. The Department shall notify the employing or contracting service agency in writing of its final determination after affording the employing or contracting service agency the opportunity to take the actions specified in Section 8.505.4.E. The Department shall recoup one hundred percent of the increased funding received but did not use for a direct benefit for direct support professionals if the employing or contracting service agency:

1. fails to respond to a notice of determination of the Department within the time provided in Section 8.505.4.E;

2. is unable to provide documentation of compliance; or

3. the Department does not accept the Plan of Correction submitted by the service agency, or is not completed within the established timeframe pursuant to Section 8.505.4.F.

I. All recoveries will be conducted pursuant to Section 25.5-4-301~~, C.R .S.~~ and ~~10 CCR 2505 10,~~ Section 8.076.3.

8.506 CHILDREN'S HOME AND COMMUNITY- BASED SERVICES WAIVER PROGRAM

8.506.1 Legal Basis:

The Children's Home and Community -bBased Services program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CHCBS program is also authorized under state law at ~~C.R.S. §~~Section 25.5-6-901, et seq. ~~- as amended.~~C.R.S.

8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.506.3.B and the additional operations specifically defined for this waiver in Section 8.506.4.B.

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552

8.506.3 General Definitions

A. Assessment means a comprehensive evaluation with the individual 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 individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved instrument to complete assessments.

B. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs. Additional operations specifically defined for this waiver are described in Section 8.506.4.B.

C. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency.

D. Continued Stay Review means a reassessment by the case manager to determine the ~~client~~Client's continued eligibility and functional level of care.

E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital or skilled nursing facility.

F. County Department means the Department of Human or Social Services in the county where the resident resides.

G. Department means the Department of Health Care Policy and Financing.

H. Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.

I. Functional Eligibility means that the ~~client~~Client meets the criteria for ~~long term~~long-term care services as determined by the Department's prescribed instrument.

J. Institutional Placement means residing in an acute care hospital or nursing facility.

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

L. Performance and Quality Review means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by a Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements.

M. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery and utilization of services.

M. Professional Medical Information Page (PMIP) ~~means the medical information signed by a licensed medical professional used as a component of the Department approved assessment tool to determine the client~~Client~~'s need for institutional care.~~ means the medical information form signed by a licensed medical professional used to certify Level of Care.

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

O. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1

P. Utilization Review Contractor (URC) means the ~~Department or~~ the agency or agencies contracted with the Department to review the CHCBS waiver application for confirmation that functional eligibility and targeting criteria are met.

8.506.4 Benefits

8.506.4.A Home and Community ~~-~~ b~~B~~ased Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at Section 26-1-114, C.R.S.~~, as amended.~~

2. Case Management Agencies will complete all administrative functions of a ~~client~~Client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

   a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of ~~client~~Client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted

for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.

b. At the time of making the initial face-to-face contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.

c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

d. Verify that the child meets the eligibility requirements outlined in ~~Client~~Client Eligibility, Section 8.506.6.

e. Submit the assessment and documentation of the enrollment application to the ~~Utilization Review Contractor~~URC to ensure the targeting criteria and functional eligibility criteria are met. Minimum documents required:

i. Initial Enrollment Form

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the approved initial enrollment form to the County Department for activation of a Medicaid State Identification Number.

g. Develop the Support Planning document in accordance with Section 8.506.4.B.7.

h. Develop a Cost Containment Record in accordance with Section 8.506.12 at the time that the Support Planning is completed.

i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with Section 8.506.10.

4. Continued Stay Review

a. Complete a new Assessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved by the ~~Utilization Review Contractor~~URC. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.).

b. Review and revise the Support Planning document in accordance with Section 8.506.4.B.7.

c. Calculate expected costs to the Medicaid Program, as set forth in Section 8.506.12, for the redetermination period.

d. Notify the county technician of the renewed ~~Long Term~~Long-term Care certification.

5. Discharge/Withdrawal

a. At the time that the ~~client~~Client no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:

i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.

ii. Submit a Department designated Discharge form to the ~~Utilization Review Contractor~~URC.

iii. Submit PAR termination to the Department's Fiscal Agent.

iv. Notify County Department of termination.

v. Notify agencies providing services to the ~~client~~Client that the child has been discharged from the waiver.

6. Transfers

a. Sending agency responsibilities:

i. Contact the receiving case management agency by telephone and provide notification that:

1) The child is planning to transfer, per the parent(s) or guardian choice.

2) Negotiate an appropriate transfer date.

3) Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.

ii. Using a State designated form, notify the ~~Utilization Review Contractor~~URC of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.

iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual ~~(~~9 CCR 2503-5~~), Case Transfer~~ Section 3.560 Case Transfers.~~.~~

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, ~~§~~ Sectino 3.560 is available at ~~http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6389.~~ Pursuant to ~~§~~ Section 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for

public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

b. Receiving agency responsibilities

i. Conduct a fact-to-face visit with the child within ten (10) working days of the child's transfer. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.)., and

ii. Review and revise the Support Planning document and the Prior Approval Cost Containment Record and change or coordinate services and providers as necessary.

7. Support Planning

a. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community-_based services. A signature from the parent(s) or guardian is required on this state designated form.

b. Documentation that the ~~client~~Client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the ~~client~~Client understands his/her right to change providers

b. On a monthly basis, evaluate the effectiveness of the Support Planning document by monitoring services provided to the child. This monitoring may include:

i. Conducting child, parent(s) or guardian, and provider interviews.

ii. Reviewing cost data.

iii. Reviewing any written reports received.

8. Performance and Quality Review

a. The Department shall conduct a Performance and Quality Review of the Children's Home and Community-_b~~B~~ased Services program to ensure that the Case Management Agency is in compliance with all statutory and regulatory requirements.

b. A Case Management Agency found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but not limited to:

i. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;

ii. A detailed ~~time-frame~~timeframe for completing the actions to be taken;

iii. The employee(s) responsible for implementing the actions; and

iv. The estimated date of completion.

c. The Case Management Agency shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The Case Management Agency shall explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.

i. Upon receipt of the proposed Corrective Action Plan, the Department will notify the Case Management Agency in writing whether the Corrective Action Plan has been accepted, modified, or rejected.

ii. In the event that the Corrective Action Plan is rejected, the Case Management Agency shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

iii. The Case Management Agency shall begin implementing the Corrective Action Plan upon acceptance by the Department.

iv. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.506.4.C In Home Support Services:

1. IHSS for CHCBS ~~client~~Clients shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.

2. Family members of a ~~client~~Client can only be reimbursed for extraordinary care.

8.506.4.D CHCBS ~~client~~Clients are eligible for all other Medicaid state plan benefits.

8.506.5 Non-Benefit

8.506.5.A Tasks defined as Personal Care or Homemaker in Section 8.552 are not benefits of this waiver.

8.506.6 Client Eligibility

8.506.6.A An eligible ~~client~~Client shall meet the following requirements:

1. Targeting Criteria:

a. Not have reached his/her eighteenth (18th) birthday.

b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Functional Eligibility:

a. The ~~Utilization Review Contractor~~URC certifies, through the Case Management Agency completed assessment, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.

3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.

4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

8.506.6.B Financial Eligibility

1. Parental income and/or resources will result in the child being ineligible for Medicaid benefits.

2. The income and resources of the child do not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance

3. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, Long-Term Care Medical Assistance Eligibility, Consideration of Trusts in Determining Medicaid Eligibility, Section 8.100.7.E.

8.506.6.C Roles of the County Department

1. Processing the Disability Determination Application through the contracted entity determined by the Department.

2. Certify that the child's income and/or resources does not exceed 300% of SSI.

3. Ensure that the parent(s) or guardian is in contact with a case management agency.

4. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility within five (5) workings days of determination.

8.506.7 Waiting List

8.506.7.A The number of ~~client~~Clients who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.

8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

8.506.7.C The waiting list shall be maintained by the ~~Utilization Review Contractor~~URC.

8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the ~~Utilization Review Contractor~~URC will use for the individual's placement on the waiting list.

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the ~~Utilization Review Contractor~~URC will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the ~~Utilization Review Contractor~~URC that an opening for the CHCBS waiver is available the Case Management Agency shall:

1. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

2. Update the existing functional level of care assessment in the official ~~client~~Client record.

3. Reassess for eligibility criteria as set forth at 8.506.6.

4. Notify the ~~Utilization Review Contractor~~URC of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.8 Provider Eligibility

8.506.8.A Providers shall enter into an agreement with the Department to conform to all federal and state established standards for the specific service they provide under the HCBS-CHCBS waiver.

8.506.8.B Providers must comply with the requirements of ~~10 CCR 2505-10,~~ Section 8.130.

8.506.8.C Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure statute and regulations.

8.506.8.D IHSS providers shall comply with IHSS Rules in Section 8.552.

8.506.9 Provider Responsibilities

8.506.9.A CHCBS providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining, and terminating employees;

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to Ssection C.R.S. 19-3-307 C.R.S(2016).

8.506.9.B CHCBS Providers shall:

1. Ensure a clientClient is not discontinued or refused services unless documented reasonable efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure clientClient records and documentation of services are made available at the request of the case manager, Department, or Utilization Review ContractorURC.

3. Ensure that adequate records are maintained.

   a. Client records shall contain:

      i. Name, address, phone number and other identifying information for the clientClient and the clientClient's parent(s) and/or legal guardian(s).

      ii. Name, address and phone number of child's Case Manager.

      iii. Name, address and phone number of the clientClient's primary physician.

      iv. Special health needs or conditions of the clientClient.

      v. Documentation of the specific services provided, including:

         a. Name of individual provider.

         b. The location for the delivery of services.

         c. Units of service.

         d. The date, month and year of services and, if applicable, the beginning and ending time of day.

      x. Documentation of any changes in the clientClient's condition or needs, as well as documentation of action taken as a result of the changes.

      xi. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.2.

      xii. Documentation of communication with the clientClient's case manager.

      xiii. Documentation of communication/coordination with any additional providers.

   b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.506.

v. A copy of the employee's job description.

4. Ensure all care provided is coordinated with any other services the ~~client~~Client is receiving.

8.506.9.C Responsibilities specific to IHSS Provider Agencies

1. Eligible IHSS Agencies will conform to all certification standards set forth at 10 C.C.R 2505-10, Section 8.552.5

2. IHSS Agencies will adhere to all responsibilities outlined at 10 C.C.R. 2505.10, Section 8.552.6

3. Ensure that only Health Maintenance Activities are delivered to CHCBS ~~client~~Clients through the IHSS benefit.

8.506.9.D Responsibilities Specific to Case Management Agencies

1. Case Management Agencies will obtain a specific authorization to provide CHCBS case management benefits to ~~client~~Clients as set forth in Provider Enrollment Section 8.487.

2. Verify that the IHSS care plan developed by IHSS providers is in accordance with both Sections 8.506.4.C and 8.552 of this volume.

3. Case Management Agencies must submit all documentation requested by the Department to complete a Performance and Quality Review within the timeframe specified by the Department.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a ~~Prior Authorization Request (~~PAR~~)~~ form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the Support Planning document.

8.506.10.C The first date for which services can be authorized is the latest date of the following:

1. The financial eligibility start date, as determined by the financial eligibility site.

2. The assigned start date on the certification page of the Assessment.

3. The date, on which the ~~client~~Client's parent(s) and/or legal guardian signs the Support Planning document or Intake form, as prescribed by the Department, agreeing to receive services.

8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Assessment.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Support Planning document results in a change in services.

8.506.10.F The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.

8.506.10.G Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.

~~8.506.10.H A revised PAR shall not be submitted if services on the Support Planning document are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness~~.

8.506.10.~~I~~H The Long-Term Care Notice of Action Form (LTC-803) shall be completed in the Information Management System (IMS) (as defined at 8.519.1.Z) for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, or at the time of discontinuation.~~If services are decreased without the client's parent(s) and/or legal guardian agreement, the case manager shall notify the client's parent(s) and/or legal guardian of the adverse action and appeal rights using the LTC 803 form in accordance with the 10-day advance notice period.~~

8.506.11 Reimbursement

8.506.11.A Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

8.506.12 Cost Containment

8.506.12.A The Department is responsible for ensuring that, on average, services delivered to the child are within the Department's cost containment requirements for the respective level of institutional care.

8.506.12.B The case manager must identify costs as part of the Support Planning document. This Cost Containment Record shall be on a Department prescribed form and include all estimated:

1. Waiver benefit services and units, as defined at 8.506.2.

2. State Plan benefit services and units.

8.506.12.C The costs of the benefit services identified in the Cost Containment Record shall be totaled and divided by the number of days remaining before the end of the child's current enrollment period.

8.506.12.D The cost per day for the child shall be compared against the Department designated cost per day of institutional care to determine cost effectiveness.

8.506.12.E The Case Manager will revise the child's Cost Containment Record anytime that a significant change in the Support Planning document results in an increase or change in the services to be provided.

8.506.12.F The Case Manager will submit the Cost Containment Record to the ~~Utilization Review Contractor~~URC for approval at the time of the child's initial enrollment onto the CHCBS waiver, or any time that a revision to the Cost Containment Record increases by a Department prescribed amount.

8.506.12.G Approval of the Cost Containment Record by the Department only ensures that the cost of the services does not exceed the equivalent cost of the appropriate institutional care.

8.506.12.H Approval of the Cost Containment Record form does not constitute approval of Medicaid reimbursement for authorized services identified within the record.

8.507 INCREASE OF THE REIMBURSEMENT RATE RESERVED FOR COMPENSATION OF DIRECT CARE WORKERS

8.507.1 DEFINITIONS

Definitions below only apply to Section 8.507.

A. Compensation means any form of monetary payment, including bonuses, employer-paid health and other insurance programs, paid time off, payroll taxes that are proportionate to the increase in compensation, and all other fixed and variable benefits conferred on or received by all Direct Care Workers providing services as enumerated below.

B. Direct Benefit means compensation that is directly conferred onto Direct Care Workers for their sole benefit and does not include direct benefits to the Home Care Agency which may have an indirect benefit to the Direct Care Workers.

C. Direct Care Worker means a non-administrative employee of a Home Care Agency who assists persons receiving personal care, homemaking, and/or In-Home Support Services in the home or community.

D. Home Care Agency means any sole proprietorship, partnership, association, corporation, government or governmental subdivision or agency subject to the restrictions in Section 25-1.5-103 (1)(a)(II), C.R.S., not-for-profit agency, or any other legal or commercial entity that manages and offers, directly or by contract, skilled home health services or personal care services to a home care consumer in the home care consumer's temporary or permanent home or place of residence. For the purposes of this section, home care agency includes only agencies providing the waiver services listed in Section 8.507.2(A) without regard to whether the agency is licensed to provide such services.

E. Payroll tax means taxes that are paid or withheld by the employer on the employee's behalf such as Social Security tax, Medicare tax, and Medicare surtax.

F Plan of Correction means a formal, written response from a Home Care Agency to the Department on identified areas of non-compliance with requirements listed at Section 25.5-6-1602-1603, C.R.S.

8.507.2 REIMBURSEMENT RATE INCREASE

A. Effective January 1, 2020, the Department increased reimbursement rates by eight and one-tenth percent which is to be reserved for compensation to Direct Care Workers above the rate of compensation that the Direct Care Workers received as of June 30, 2019. One hundred percent of the eight and one-tenth percent rate increase must be used as compensation for the Direct Care Workers. The following services delivered through Home and Community-~~-~~b~~B~~ased Waivers will receive the eight and one-tenth percent increase to reimbursement rates:

1. Homemaker Basic

2. Homemaker Enhanced

3. Personal Care

4. In-Home Support Services

    a. Exclusion: Health Maintenance Activities

B Consumer Directed Attendant Support Services (CDASS) and Pediatric Personal Care are excluded from this Section 8.507

C. Items or expenses for which funding from the 2019-20 fiscal year reimbursement rate increase may not be used for, include, but are not limited to, the following:

1. Executive Salaries
2. Administrative Expenses
3. Human Resource Expenses
4. Information Technology
5. Oversight Expenses
6. Business Management Expenses
7. General Record Keeping Expenses
8. Budget and Finance Expenses
9. Workers' Compensation Insurance
10. Contract Staffing Agency Expenses
11. Employee Appreciation Events
12. Gifts
13. Activities not identifiable to a single program.

D. In the event that a Direct Care Worker was hired after June 30, 2019, the Home Care Agency shall use the lowest compensation paid to a Direct Care Worker of similar functions and duties as of June 30th, 2019. This is the base rate that the increased compensation will be applied to.

E. On and after July 1, 2020, the hourly minimum wage for Direct Care Workers providing personal care services, homemaker services, and In-Home Support Services is $12.41 per hour.

F. For any increase to the reimbursement rates for the above services that takes effect during the 2020-21 fiscal year, agencies shall use eighty-five percent of the funding to increase compensation for Direct Care Workers above the rate of compensation that the Direct Care Workers received as of June 30, 2020.

1. Home Care Agencies may use any remaining funding resulting from the reimbursement rate increase for general and administrative expenses, such as chief executive office salaries, human resources, information technology, oversight, business management, general record keeping, budgeting and finance, and other activities not identifiable to a single program.

G. Within sixty days after rate increases are approved, each Home Care Agency shall provide written notification to each Direct Care Worker who provides the above services of the compensation they are entitled to.

8.507.3 REPORTING REQUIREMENTS FOR DIRECT CARE WORKER RATE INCREASES

A. On or before December 31, 2020, and one (1) year thereafter, Home Care Agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-1602, C.R.S. were used to increase compensation for Direct Care Workers in the 2019-20 fiscal year. On or before December 31, 2021, Home Care Agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-1602, C.R.S. were used to increase compensation for the 2020-21 fiscal year. If there is no reimbursement rate increase, Home Care Agencies must report and attest to the Department in detail how they maintained each Direct Care Worker's compensation for the 2020-21 fiscal year.

1. Home Care Agencies must report to the Department, in the manner prescribed by the Department, by December 31 of each year.

2. The Department has ongoing discretion to request information from Home Care Agencies demonstrating how it maintained increases in compensation for Direct Care Workers beyond the reporting period.

3. Failure to provide adequate and timely reports may result in recoupment of funds.

8.507.4 AUDITING REQUIREMENTS FOR DIRECT CARE WORKERS INCREASE FOR COMPENSATION

A. Each Home Care Agency shall keep true and accurate work records to support and demonstrate use of the funds. Such records shall be retained for a period of not less than three (3) years and shall be open to inspection by the Department and are made available to be copied by the Department or its authorized representatives at any reasonable time and as often as may be necessary.

B. Home Care Agencies shall submit to the Department upon request, only records showing that the funds received for the services listed in Section 8.507.2.A. were used as a compensation for Direct Care Workers, including but not limited to:

1. Federal Employment Forms

   a W2 - Wage and Tax Statement

   b. W3 - Transmittal of Wage and Tax Statement

   c. 941 - Employer's Quarterly Federal Unemployment Tax Return

   d. 940 - Employer's Annual Federal Unemployment Tax Return

2. State Employment Forms

   a. UITR 1 – State Unemployment Insurance Tax Report

   b. UITR 1A - State Unemployment Insurance Tax Report Wage List

3. Business/Corporate Tax Returns

4. Independent Contractor Forms

   a. 1099's- Miscellaneous Income

   b. 1096 - Annual Summary and Transmittal of U.S. Information Returns

5. Payroll Records

    a. Payroll Detail

    b. Payroll Summary

6. Accounting Records

    a. Chart of Accounts

    b. General Ledger

    c. Profit & Loss Statements

    d. Check Register

7. Bank Statements

8. Timesheets

9. Benefits Records

    a. Health Insurance Records

    b. Other Insurance Records

    c. Paid Time Off Records

D. The Department may recoup part or all ~~of~~ the funding resulting from the increase in the reimbursement rate if the Department determines that the Home Care Agency:

1. Did not use one hundred percent of any funding resulting from the rate increase to increase compensation for Direct Care Workers during fiscal year 2019-2020, as required by Section 25.5-6-1602(2), C.R.S.

2. Did not use eighty-five percent of the funding resulting from the rate increase to increase compensation for Direct Care Workers during fiscal year 2020-2021

3. Failed to track and report how it used any funds resulting from the increase in the reimbursement rate

E. If the Department makes a determination to recoup funding, the Department shall notify the Home Care Agency in writing of the Department's intention to recoup funds. The Home Care Agency has forty-five (45) days after issuance of the notice of the determination to complete any of the following actions:

1. Challenge the determination of the Department;

2. Provide additional information to the Department demonstrating compliance;

3. Submit a Plan of Correction to the Department.

F. The Home Care Agency must submit the Plan of Correction to the Department within forty-five (45) business days of the issuance of a written request from the Department. The Home Care Agency must notify the Department in writing, within five (5) business days of the receipt of the

written request from the Department, if it will not be able to submit the Plan of Correction by the due date. The Home Care Agency must explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the Home Care Agency's compliance.

G. A Plan of Correction shall include, but not be limited to:

1. A detailed description of actions to be taken to resolve issues and supporting documentation demonstrating completion.

2. A detailed plan specifying the actions to be taken.

3. Employee(s) responsible for implementing the actions.

4. The implementation timeframes and date(s) for completion.

H. Upon receipt of the Plan of Correction, the Department will accept, request modifications, or reject the proposed Plan of Correction. Modifications or rejections will be accompanied by a written explanation. If a Plan of Correction is rejected, the Home Care Agency must resubmit a new Plan of Correction along with any requested documentation to the Department for review within five (5) business days of notification.

I. The Department shall notify the Home Care Agency in writing of its final determination after affording the Home Care Agency the opportunity to take the actions specified in Section 8.507.4.E. The Department shall recoup one hundred percent of the increased funding received but did not use for a direct benefit for non-administrative employee if the Home Care Agency:

1. fails to respond to a notice of determination of the Department within the time provided in Section 8.507.4.E;

2. is unable to provide documentation of compliance; or

3. the Department does not accept the Plan of Correction submitted by the service agency; or

4. Plan of Correction is not completed within the established timeframe pursuant to Section 8.507.4.I.

J. All recoveries will be conducted pursuant to Section 25.5-4-301, C.R.S. and Section 8.076.3.

8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

8.508.10 LEGAL BASIS

The Home and Community ~~-b~~Based Services- Children's Habilitation Residential Program (HCBS-CHRP) 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. § 1396a. The 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. § 1396n.

8.508.20 DEFINITIONS

A. Abuse: As defined at ~~§25.5-10-202 (1) (a)-(c), C.R.S.~~§§ 16-22-102 (9) C.R.S., § 19-1-103, C.R.S., § 25.5-10-202 (1) (a)-(c), C.R.S., and § 26.3.1-101 C.R.S.~~.~~

B. Adverse Action: A denial, reduction, termination, or suspension from a Long-Term Services and Supports (LTSS) program or service.

C. Applicant: A child or youth who is seeking a Long-Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. Caretaker: As defined at ~~§~~ Section 25.5-10-202 (1.6)(a)-(c), C.R.S.

E. Caretaker neglect: As defined at ~~§~~ Section 25.5-10-202 (1.8)(a)-(c), C.R.S.

F. Case Management Agency (CMA): A public or private not-for-profit for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-~~-b~~Based Services waivers pursuant to sections 25.5-10-209.5 C.R.S. and pursuant to a provider participation agreement with the state department.

G. Child Placement Agency: As defined at 12 CCR 2509-8; ~~§~~ Section 7.701.2 (F).

H. Client: A child or youth who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-~~-b~~Based Services (HCBS)

I. Client Representative: A person who is designated to act on the Client's behalf. A Client Representative may be: (a) a legal representative including, but not limited to a court-appointed guardian, or a parent of a minor child; or (b) an individual, family member or friend selected by the ~~client~~Client to speak for an/or act on the ~~client~~Client's behalf.

J. Community Centered Board: A private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-~~-b~~Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of state funded programs for individuals with intellectual and developmental disabilities.

K. Complex Behavior: Behavior that occurs related to a diagnosis by a licensed physician, psychiatrist, or psychologist that includes one or more substantial disorders of the cognitive, volitional or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior.

L. Complex Medical Needs: Needs that occur as a result of a chronic medical condition as diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12) months, requires skilled care, and that without intervention may result in a severely life altering condition.

M. Comprehensive Assessment: An initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the ~~client~~Client experiences significant change in need or in level of support.

N. Cost Containment: Limiting the cost of providing care in the community to 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-~~b~~Based Services, and Medicaid State Plan benefits including long- term home health services and targeted case management.

O. Criminal Activity: A criminal offense that is committed by a person; a violation of parole or probation; and any criminal offense that is committed by a person receiving services that results in immediate incarceration.

P. Crisis: An event, series of events, and/or state of being greater than normal severity for the ~~Client~~Client and/or family that becomes outside the manageable range for the Client and/or their family and poses a danger to self, family, and/or the community. Crisis may be self-identified, family identified, and/or identified by an outside party.

Q. Critical Incident: Incidents of Mistreatment; Abuse; Neglect; Exploitation, Criminal Activity; Damage to Client's Property/Theft; Death unexpected or expected; Injury/Illness to Client; Medication Mismanagement; Missing Person; Unsafe Housing/Displacement; and/or Other Serious Issues.

R. Department: The Colorado Department of Health Care Policy and Financing the single state Medicaid agency.

S. Damage to Client's Property/Theft: Deliberate damage, destruction, theft or use a Client's belongings or money. If the incident involves Mistreatment by a Caretaker that results in damage tor Client's property or theft in the incident shall be listed as Mistreatment.

T. Developmental Delay: A child who is:

1. Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:

   i. Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age;

   ii. Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development;

   iii. Has an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or

2. Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a CCB.

U. Early and Periodic Screening Diagnosis and Treatment (EPSDT): As defined in Section 8.280.1.

V. Exploitation: As defined in §Sections 25.5-10-202(15.5)(a)-(d) and ~~, C.R.S., §~~ 26.3.1-101 C.R.S.

W. Extraordinary Needs: A level of care due to Complex Behavior and/or Medical Support Needs that is provided in a residential child care facility or that is provided through community-~~-~~based programs, and without such care, would place a child at risk of unwarranted child welfare involvement or other system involvement.

X. Family: As defined at ~~§~~ Section 25.5-10-202 ~~)~~(16)(a)(I)-(IV)(b), C.R.S.

Y. Foster Care Home: A family care home providing 24-hour care for a child or children and certified by either a County Department of Social/Human Services or a child placement agency. A Foster Care Home, for the purposes of this waiver, shall not include a family member as defined in ~~§~~ Section 25.10-202 (16)(a)(I)-(IV)(b), C.R.S.

Z. Guardian: An individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not guardian ad litem.

AA. Guardian ad litem or GAL": A person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963", set forth in Aarticle 33 of Title 22, C.R.S.

~~AA.~~BB. Harmful Act: as defined at Section~~§~~ 25.5-10-202 (18.5) and ~~§~~ 26.3.1-101 C.R.S.

~~BB.~~CC. Home and Community-~~ b~~Based Services (HCBS) Waivers: Services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

~~CC.~~DD. Increased Risk Factors: Situations or events that when occur at a certain frequency or pattern historically have led to Crisis.

~~DD.~~EE. Informed Consent: An assent that is expressed in writing, freely given, and preceded by the following:

1. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

2. A description of the attendant discomforts and risks;

3. A description of the expected benefits;

4. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

5. An offer to answer any inquiries regarding the procedure(s);

6. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

7. A statement that withholding or withdrawal of consent shall not prejudice future availability of services and supports.

~~EE.~~FF. Injury/Illness to Client: An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, and skin wounds; an injury or illness requiring immediate emergency medical treatment to preserve life or limb; an emergency medical treatment that results in admission to the hospital; and a psychiatric crisis resulting in unplanned hospitalization.

~~FF.~~GG. Institution: A hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the State Plan.

~~GG.~~HH. Intellectual and Developmental Disability: A disability that manifests before the person reaches twenty-two (22) years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general

intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15001 et seq., does not apply.

"Impairment of general intellectual functioning" The person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. when an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

"Adaptive behavior similar to that of a person with intellectual and developmental disabilities" The person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

"Substantial intellectual deficits" An intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

~~HH.~~II. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID): A publicly or ~~privately operated~~privately-operated facility that provides health and habilitation services to a ~~client~~Client with intellectual or developmental disabilities or related conditions.

~~II.~~JJ. Kin: As defined in 12 CCR 2509-1, Section 7.000.2.A.

~~JJ.~~KK. Kinship Foster Care Home: As defined in 12 CCR 2509-1, Section 7.000.2.A.

~~KK.~~LL. Level of Care (LOC): The specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

~~LL.~~MM. Level of Care Determination: An eligibility determination by a CCB of an Individual for a Long-Term Services and Supports (LTSS) program.

~~MM.~~NN. Level of Care Evaluation: A comprehensive evaluation with the Individual seeking services and others chosen by the Individual to participate, conducted by the case manager utilizing the Department's prescribed tool, with supporting diagnostic information from the Individual's medical providers, for the purpose of determining the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports (LTSS) programs.

~~NN.~~OO. Licensed Child Care Center (less than 24 hours): As defined in Section~~§~~ 26-6-102 (5), C.R.S. and as described in ~~-~~12 CCR 2509-8; Section ~~§~~7.701.

~~OO.~~PP. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Clients of all ages with functional limitations and chronic illnesses who need assistance

to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

~~PP.~~QQ. Medicaid Eligible: The Applicant or Client meets the criteria for Medicaid benefits based on the financial determination and disability determination.

~~QQ.~~RR. Medicaid State Plan: The federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

~~RR.~~SS. Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

~~SS.~~TT. Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or there is a risk to public safety.

~~TT.~~UU. "Mistreated" or "Mistreatment": As defined at ~~§~~ Section 25.5-10-202(29.5)(a)-(d~~e~~)~~, C.R.S.~~, and § 26.3.1-101 ~~C.R.S~~.

~~UU.~~VV. Natural Supports: Unpaid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

~~VV.~~WW. Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.

~~WW.~~XX. Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or lesser likelihood of success of Crisis interventions.

~~XX.~~YY. Prior Authorization: Approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the CMA.

~~YY.~~ZZ. Professional: Any person, not including family, performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

~~ZZ.~~AAA. Professional Medical Information Page (PMIP): The medical information form signed by a Licensed Medical Professional used to ~~verify that a Client needs institutional Level of Care.~~certify Level of Care.

~~AAA.~~BBB. Relative: A person related to the Client by blood, marriage, adoption or common law marriage.

~~BBB.~~CCC. Residential Child Care Facility: As defined in 12 CCR 2509-8, Section ~~.~~7.705.1.

~~CCC.~~DDD. Retrospective Review: The Department's review after services and supports are provided to ensure the Client received services according to the service plan and standards of economy, efficiency and quality of service.

~~DDD.~~EEE. Separation: The restriction of a Client for a period of time to a designated area from which the is not physically prevented from leaving, for the purpose of providing the Client an opportunity to regain self-control.

~~EEE.~~FFF. Service Provider: A Specialized Group Facility, Residential Child Care Facility, Foster Care Home, Kinship Foster Care Home, Child Placement Agency, Licensed Child Care Facility (non-24 hours), and/or Medicaid enrolled provider.

~~FFF.~~GGG. Service Plan: The written document that specifies identified and needed services, to include Medicaid and non-Medicaid covered services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with Department regulations.

~~GGG.~~HHH. Service Planning: The process of working with the Client receiving services and people chosen by the Individual, to identify goals, needed services, and appropriate service providers based on the Comprehensive Assessment and knowledge of the available community resources. Service planning informs the Individual seeking or receiving services of his or her rights and responsibilities.

~~HHH.~~III. Specialized Group Facility: As defined in 12 CCR 2509-8; Section~~§~~ 7.701.2(B).

~~III.~~JJJ. Support: Any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

~~JJJ.~~KKK. Support Level: A numeric value determined by the Support Need Level Assessment that places Clients into groups with other Clients who have similar overall support needs.

~~KKK.~~LLL. Support Need Level Assessment: The standardized assessment tool used to identify and measure the support requirements for HCBS-CHRP waiver participants.

~~LLL.~~MMM. Targeted Case Management (TCM): Has the same meaning as in Section 8.761.

~~MMM.~~NNN. Third Party Resources: Services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to community resources, services provided through private insurance, non-profit services and other government programs.

~~NNN.~~OOO. Unsafe Housing/Displacement: An individual residing in an unsafe living condition due to a natural event (such as fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.

~~OOO.~~PPP. Waiver Service: Optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

~~PPP.~~QQQ. Wraparound Facilitator: A person who has a ~~Bachelor's~~bachelor's degree in a human behavioral science or related field of study and is certified in a wraparound training program. Experience working with LTSS populations in a private or public social services agency may substitute for the ~~Bachelor's~~bachelor's degree on a year for year basis. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field. The wraparound certification must include training in the following:

Trauma informed care.

Youth mental health first aid.

Crisis supports and planning.

Positive Behavior Supports, behavior intervention, and de-escalation techniques.

Cultural and linguistic competency.

Family and youth serving systems.

Family engagement.

Child and adolescent development.

Accessing community resources and services.

Conflict resolution.

Intellectual and developmental disabilities.

Mental health topics and services.

Substance abuse topics and services.

Psychotropic medications.

Motivational interviewing.

Prevention, detection, and reporting of Mistreatment, Abuse, Neglect, and Exploitation.

~~QQQ.~~RRR. Wraparound Transition Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a transition to the family home after out of home placement.

~~RRR.~~SSS. Wraparound Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a plan to maintain stabilization, prevent Crisis, and/or for de-escalation of Crisis situations.

~~SSS.~~TTT. Wraparound Support Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

~~TTT.~~UUU. Wraparound Transition Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

8.508.30 SCOPE OF SERVICES

A. The HCBS-CHRP waiver provides services and supports to eligible children and youth with Intellectual and Developmental Disability, and who are at risk of institutionalization pursuant to 25.5-6-903, C.R.S. The services provided through this waiver serve as an alternative to ICF/IID placement for children from birth to twenty-one years (21) of age who meet the eligibility criteria and the Level of Care as determined by a Level of Care Evaluation and Determination. The services provided through the HCBS-CHRP waiver are limited to:

1. Habilitation

2. Hippotherapy

3. Intensive Support

4. Massage Therapy

5. Movement Therapy

6. Respite

7. Supported Community Connection

8. Transition Support

B. HCBS-CHRP waiver services shall be provided in accordance with these rules and regulations.

8.508.40 ELIGIBILITY

A. Services shall be provided to Clients with an Intellectual and Developmental Disability who meet all of the following eligibility requirements:

1. A determination of developmental disability by a CCB which includes developmental delay if under five (5) years of age.

2. The Client has Extraordinary Needs that put the Client at risk of, or in need of, out of home placement.

3. Meet ICF-IID Level of Care as determined by a Level of Care Evaluation.

4. The income of the Client does not exceed 300% of the current maximum SSI standard maintenance allowance.

5. Enrollment of the Client in the HCBS- CHRP waiver will result in an overall savings when compared to the ICF/IID cost as determined by the State.

6. The Client receives at least one waiver service each month.

B. A Support Need Level Assessment must be completed upon determination of eligibility. The Support Need Level Assessment is used to determine the level of reimbursement for Habilitation and per diem Respite services.

C. Clients must first access all benefits available under the Medicaid State Plan and/or EPSDT for which they are eligible, prior to accessing funding for those same services under the HCBS-CHRP waiver.

D. Pursuant to the terms of the HCBS-CHRP waiver, the number of individuals who may be served each year is based on:

1. The federally approved capacity of the waiver;

2. Cost Containment requirements under section 8.508.80;

3. The total appropriation limitations when enrollment is projected to exceed spending authority.

8.508.50 WAITING LIST PROTOCOL

A. Clients determined eligible for HCBS-CHRP services who cannot be served within the appropriation capacity limits of the HCBS-CHRP waiver shall be eligible for placement on a waiting list.

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

2. The date used to establish the Client's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.508.40 were determined to have been met and the Department was notified.

3. As openings become available within the appropriation capacity limits of the federal waiver, Clients shall be considered for services based on the date of their waiting list placement.

8.508.60 RESPONSIBILITIES OF THE CCB

A. The CCB shall make eligibility determinations for developmental disabilities services to include the Level of Care Evaluation Determination for any Applicant or Client being considered for enrollment in the HCBS-CHRP waiver.

B. Additional administrative responsibilities of CCBs as required in 8.601.

8.508.70 CASE MANAGEMENT FUNCTIONS

A. Case management services will be provided by a CMA as a Targeted Case Management service pursuant to sections 8.761.14 and 8.519 and will include:

1. Completion of a Comprehensive Assessment;

2. Completion of a Service Plan (SP);

3. Referral for services and related activities;

4. Monitoring and follow-up by the CMA including ensuring that the SP is implemented and adequately addresses the Client's needs.

5. Monitoring and follow-up actions, which shall

a. Be performed when necessary to address health and safety and services in the SP;

b. Services in the SP are adequate; and

c. Necessary adjustments in the SP and service arrangements with providers are made if the needs of the Client have changed.

6. Face to face monitoring to be completed at least once per quarter and to include direct contact with the Client in a place where services are delivered. Upon Department approval, monitoring may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.).

8.508.71 SERVICE PLAN (SP)

A. The CMA shall complete a Service Plan for each Client enrolled in the HCBS-CHRP waiver in accordance with Section 8.519.11.B and will:

1. Address the Client's assessed needs and personal goals, including health and safety risk factors either by HCBS-CHRP waiver services or any other means;

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

3. Be entered and verified in the Department prescribed system within ten (10) business days;

4. Describe the types of services to be provided, the amount, frequency, and duration of each service and the provider type for each service;

5. Include a statement of agreement by the Client and/or the legally responsible party; and

6. Be updated or revised at least annually or when warranted by changes in the Client's needs.

B. The Service Plan shall document that the Client has been offered a choice:

1. Between HCBS waivers and institutional care;

2. Among HCBS-CHRP waiver services; and

3. Among qualified providers.

8.508.72 PRIOR AUTHORIZATION REQUESTS (PAR)

A. The case manager shall submit a PAR in compliance with applicable regulations and ensure requested services are:

1. Consistent with the Client's documented medical condition and Comprehensive Assessment.

2. Adequate in amount, frequency, scope and duration in order to meet the Client's needs and within the limitations set forth in the current federally approved HCBS-CHRP waiver.

3. Not duplicative of another service, including services provided through:

a. Medicaid State Plan benefits;

b. Third Party Resources;

c. Natural Supports;

d. Charitable organizations; or

e. Other public assistance programs.

B. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to Section 8.058.4.

8.508.73 REIMBURSEMENT

A. Only services identified in the Service Plan are available for reimbursement under the HCBS-CHRP waiver. Reimbursement will be made only to licensed or certified providers, as defined in Section 8.508.160 and services will be reimbursed per a fee for service schedule as determined by the Department through the Medicaid Management Information System (MMIS).

B. Only those services not available under Medicaid EPSDT, Medicaid State Plan benefits, Third Party Resources, or other public funded programs, services or supports are available through the CHRP Waiver. All available community services must be exhausted before requesting similar services from the waiver. The CHRP Waiver does not reimburse services that are the responsibility of the Colorado Department of Education.

C. Reimbursement for Habilitation service does not include the cost of normal facility maintenance, upkeep and improvement. This exclusion does not include costs for modifications or adaptations required to assure the health and safety of Client or to meet the requirements of the applicable life safety code.

D. Medicaid shall not pay for room and board.

E. Claims for Targeted Case Management are reimbursable pursuant to Section 8.761.4-.5.

8.508.74 COMPLIANCE MONITORING

A. Services provided to a ~~client~~Client are subject to compliance monitoring by the Department pursuant to Section 8.076.2.

8.508.80 COST CONTAINMENT

Cost Containment is to ensure, on an individual Client basis, that the provision of HCBS-CHRP services is a ~~cost effective~~cost-effective alternative compared to the equivalent cost of appropriate ICF/IID institutional Level of Care. The Department shall be responsible for ensuring that, on average, each Service Plan is within the federally approved Cost Containment requirements of the waiver. Clients enrolled in the HCBS-CHRP waiver shall continue to meet the Cost Containment criteria during subsequent periods of eligibility.

8.508.100 SERVICE DESCRIPTIONS

A. Habilitation

1. Services may be provided to Clients who require additional care for the Client to remain safely in home and ~~community based~~community-based settings. The Client must demonstrate the need for such services above and beyond those of a typical child of the same age.

2. Habilitation services include those that assist Clients in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and ~~community based~~community-based settings.

3. Habilitation services under the HCBS-CHRP waiver differ in scope, nature, supervision, and/or provider type (including provider training requirements and qualifications) from any other services in the Medicaid State Plan.

4. Habilitation is a twenty-four (24) hour service and includes the following activities:

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

b. Self-advocacy training and support which may include assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing Abuse, Neglect, Mistreatment, and/or Exploitation of self, responsibility for one's own actions, and participation in meetings.

c. Cognitive services which includes assistance with additional concepts and materials to enhance communication.

d. Emergency assistance which includes safety planning, fire and disaster drills, and crisis intervention.

e. Community access supports which includes assistance developing the abilities and skills necessary to enable the Client to access typical activities and functions of community life such as education, training, and volunteer activities. Community access supports includes providing a wide variety of opportunities to develop socially appropriate behaviors, facilitate and build relationships and Natural Supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the Client's Service Plan. These activities are conducted in a variety of settings in which the Client interacts with non-disabled individuals (other than those individuals who are providing services to the Client). These services may include socialization, adaptive skills, and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement and are based on the interest of the Client.

f. Transportation services are encompassed within Habilitation and are not duplicative of the non-emergent medical transportation that is authorized in the Medicaid State Plan. Transportation services are more specific to supports provided by Foster Care Homes, Kinship Foster Care Homes, Specialized Group Facilities, and Residential Child Care Facilities to access activities and functions of community life.

g. Follow-up counseling, behavioral, or other therapeutic interventions, and physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

h. Medical and health care services that are integral to meeting the daily needs of the Client and include such tasks as routine administration of medications or providing support when the Client is ill.

B. Habilitation may be provided in a Foster Care Home or Kinship Foster Care Home certified by a licensed Child Placement Agency or County Department of Human Services, Specialized Group Facility licensed by the Colorado Department of Human Services, or Residential Child Care Facility licensed by the Colorado Department of Human Services.

1. Habilitation capacity limits:

a. A Foster Care Home or Kinship Foster Care Home may serve a maximum of one (1) Client enrolled in the HCBS-CHRP waiver and two (2) other foster children, or

two (2) Clients enrolled in the HCBS-CHRP waiver and no other foster children, unless there has been prior written approval by the Department. Placements of three (3) Clients approved for the HCBS-CHRP waiver may be made if the Service Provider can demonstrate to the Department that the Foster Care Home provider has sufficient knowledge, experience, and supports to safely meet the needs of all of the children in the home. In any case, no more than three (3) Clients enrolled in the HCBS-CHRP waiver will be placed in the same foster home. Emergency placements will not exceed the maximum established limits. Foster Care Homes that exceed established capacity at the time the rule takes effect will be grandfathered in; however, with attrition, capacity must comply with the rule.

Foster Care Home Maximum Capacity

HCBS-CHRP waiver	Non HCBS-CHRP	Total Children
1	2	3
2	0	2
3	0	3

b. Placement of a Client in a Specialized Group Facility is prohibited if the placement will result in more than eight (8) children including one (1) Client enrolled in the HCBS-CHRP waiver, or five (5) foster children including two (2) Clients enrolled in the HCBS-CHRP waiver, unless there has been prior written approval by the Department. If placement of a child in a specialized group Facility will result in more than three (3) Clients enrolled in the HCBS-CHRP waiver, then the total number of children placed in that specialized group Facility must not exceed a maximum of six (6) total children. Placements of more than three (3) Clients enrolled in the HCBS-CHRP waiver may be made if the Service Provider can demonstrate to the he Department hat the facility staff have sufficient knowledge, experience, and supports to safely meet the needs of all of the children in the facility.

Specialized Group Facility Maximum Capacity

HCBS-CHRP waiver	Non HCBS-CHRP waiver	Total Children
1	8	9
2	5	7

c. Only one (1) HCBS-CHRP Client and two (2) HCBS- Persons with Developmental Disabilities (DD) or HCBS- Supported Living Services (SLS) waiver participants; or two (2) HCBS-CHRP participants and one HCBS-DD or HCBS-SLS waiver participant may live in the same foster care home.

C. The Service Provider or child placement agency shall ensure choice is provided to all Clients in their living arrangement.

D. The Foster Care Home or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all Clients living in the home.

E. The Service Provider shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification before any child or youth can be placed in that home. If emergency placement is needed outside of business hours, the Service Provider or child placement agency shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification the next business day.

F. Hippotherapy

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

2. Hippotherapy may be provided only when the provider is licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

3. Hippotherapy must be used as a treatment strategy for an identified medical or behavioral need.

4. Hippotherapy must be an identified need in the Service Plan.

5. Hippotherapy must be recommended or prescribed by a licensed physician or therapist who is enrolled as a Medicaid provider. The recommendation must clearly identify the need for hippotherapy, recommended treatment, and expected outcome.

6. The recommending therapist or physician must monitor the progress of the hippotherapy treatment at least quarterly.

7. Hippotherapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT, or from a Third--Party Resource.

8. Equine therapy and therapeutic riding are excluded.

G. Intensive Support

1. This service aligns strategies, interventions, and supports for the Client, and family, to prevent the need for out of home placement.

2. This service may be utilized in maintaining stabilization, preventing Crisis situations, and/or de-escalation of a Crisis.

3. Intensive support services include:

   a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the child or youth and family.

   b. Identification of needs for Crisis prevention and intervention including, but not limited to:

      i. Cause(s) and triggers that could lead to a Crisis.

      ii. Physical and behavioral health factors.

      iii. Education services.

      iv. Family dynamics.

      v. Schedules and routines.

      vi. Current or history of police involvement.

      vii. Current or history of medical and behavioral health hospitalizations.

viii. Current services.

ix. Adaptive equipment needs.

x. Past interventions and outcomes.

xi. Immediate need for resources.

xii. Respite services.

xiii. Predictive Risk Factors.

xiv. Increased Risk Factors.

4. Development of a Wraparound Plan with action steps to implement support strategies, prevent, and/or manage a future Crisis to include, but not limited to:

a. The unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and family.

b. Environmental modifications.

c. Support needs in the family home.

d. Respite services.

e. Strategies to prevent Crisis triggers.

f. Strategies for Predictive and/or Increased Risk Factors.

g. Learning new adaptive or life skills.

h. Behavioral or other therapeutic interventions to further stabilize the Client emotionally and behaviorally and to decrease the frequency and duration of any future behavioral Crises.

i. Medication management and stabilization.

j. Physical health.

k. Identification of training needs and connection to training for family members, Natural Supports, and paid staff.

l. Determination of criteria to achieve stabilization in the family home.

m. Identification of how the plan will be phased out once the Client has stabilized.

n. Contingency plan for out of home placement.

o. Coordination among Family caregivers, other Family members, service providers, Natural Supports, Professionals, and case managers required to implement the Wraparound Plan.

p. Dissemination of the Wraparound Plan to all individuals involved in plan implementation.

5. In-Home Support.

   a. The type, frequency, and duration of in-home support services must be included in a Wraparound Plan.

   b. In-Home Support Services include implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the child or youth with self-care, learning self-advocacy, and protective oversight.

   c. Service may be provided in the Client's home or community as determined by the Wraparound Plan.

6. Follow-up services.

   a. Follow-up services include an evaluation to ensure that triggers to the Crisis have been addressed in order to maintain stabilization and prevent a future Crisis.

   b. An evaluation of the Wraparound Plan should occur at a frequency determined by the Client's needs and include at a minimum, visits to the Client's home, review of documentation, and coordination with other Professionals and/or members of the Wraparound Support Team to determine progress.

   c. Services include a review of the Client's stability, and monitoring of Increased Risk Factors that could indicate a repeat Crisis.

   d. Revision of the Wraparound Plan should be completed as necessary to avert a Crisis or Crisis escalation.

   e. Services include ensuring that follow-up appointments are made and kept.

7. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the Client, their Family, and their Wraparound Support Team.

8. All service and supports providers on the Wraparound Support Team must adhere to the Wraparound Plan.

9. Revision of strategies should be a continuous process by the Wraparound Support Team in collaboration with the Client, until the Client is stable and there is no longer a need for Intensive Support Services.

10. On-going evaluation after completion of the Wraparound Plan may be provided if there is a need to support the Client and his or her Family in connecting to any additional resources needed to prevent a future Crisis.

H. Massage Therapy

1. Massage therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation, and muscle tension including WATSU.

2. Children with specific developmental disorders often experience painful muscle contractions. Massage has been shown to be an effective treatment for easing muscle contracture, releasing spasms, and improving muscle extension, thereby reducing pain.

3. Massage therapists must be licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

4. The service must be used as a treatment strategy for an identified medical or behavioral need and included in the Service Plan.

5. Massage therapy services must be recommended or prescribed by a therapist or physician who is an enrolled Medicaid Provider. The recommendation must include the medical or behavioral need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the massage therapy treatment at least quarterly.

6. Massage therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.

I. Movement Therapy

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

2. Movement therapy providers must be meet the educational requirements and is certified, registered and/or accredited by an appropriate national accreditation association.

3. Movement therapy is only authorized as a treatment strategy for a specific medical or behavioral need and identified in the Client's Service Plan.

4. Movement therapy must be recommended or prescribed by a therapist or physician who is enrolled Medicaid provider. The recommendation must include the medical need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the movement therapy at least quarterly.

5. Movement Therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT or from a Third Party Resource.

J. Respite

1. Respite services are provided to children or youth living in the Family home on a short term basis because of the absence or need for relief of the primary Caretaker(s)

2. Respite services may be provided in a certified Foster Care Home, Kinship Foster Care Home, Licensed Residential Child Care Facility, Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours), in the Family home, or in the community.

3. Federal financial participation is not available for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

4. Respite care is authorized for short-term temporary relief of the Caretaker for not more than seven (7) consecutive days per month, not to exceed twenty-eight (28) days in a calendar year.

5. During the time when Respite care is occurring, the Foster Care Home or Kinship Care Home may not exceed six (6) foster children or a maximum of eight (8) total children, with

no more than two (2) children under the age of (two) 2. The respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.

6. Respite is available for children or youth living in the Family home and may not be utilized while the Client is receiving Habilitation services.

K. Supported Community Connection

1. Supported community connection services are provided one-on-one to deliver instruction for documented Complex Behavior that are exhibited by the Client while in the community, such as physically or sexually aggressive behavior towards others and/or exposing themselves.

2. Services must be provided in a setting within the community where the Client interacts with individuals without disabilities (other than the individual who is providing the service to the Client).

3. The targeted behavior, measurable goal(s), and plan to address must be clearly articulated in the Service Plan.

4. This service is limited to five (5) hours per week.

5. A request to increase service hours can be made to the Department on a case-by-case basis.

L. Transition Support

1. Transition support services align strategies, interventions, and Supports for the Client, and Family, when a Client transitions to the Family home from out-of-home placement.

2. Services include:

a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and Family.

b. Identification of transition needs including, but not limited to:

i. Cause(s) of a Crisis and triggers that could lead to a Crisis.

ii. Physical and behavioral health factors.

iii. Education services.

iv. Family dynamics.

v. Schedules and routines.

vi. Current or history of police involvement.

vii. Current or history of medical and behavioral health hospitalizations.

viii. Current services.

ix. Adaptive equipment needs.

x. Past interventions and outcomes.

xi. Immediate need for resources.

xii. Respite services.

xiii. Predictive Risk Factors.

xiv. Increased Risk Factors.

3. Development of a Wraparound Transition Plan is required, with action steps to implement strategies to address identified transition risk factors including, but not limited to:

a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and Family.

b. Environmental modifications.

c. Strategies for transition risk factors.

d. Strategies for avoiding Crisis triggers.

e. Support needs in the Family home.

f. Respite services.

g. Learning new adaptive or life skills.

h. Counseling/behavioral or other therapeutic interventions to further stabilize the Client emotionally and behaviorally to decrease the frequency and duration of future Crises.

i. Medication management and stabilization.

j. Physical health.

k. Identification of training needs and connection to training for Family members, Natural Supports, and paid staff.

l. Identification of strategies to achieve and maintain stabilization in the Family home.

m. Identification of how the Wraparound Plan will terminate once the child or youth has stabilized.

n. Coordination among Family, service providers, natural supports, professionals, and case managers required to implement the Wraparound Transition Plan.

o. Dissemination of a Wraparound Transition Plan to all involved in plan implementation.

4. In-Home Support

a. The type, frequency, and duration of authorized services must be included in the Wraparound Plan.

b. In-home support services include implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the Client with self-care, learning self-advocacy, and protective oversight.

c. Services may be provided in the Client's home or in community, as provided in the Wraparound Transition Plan.

d.

5. Follow-up services are authorized and may include:

a. Evaluation to ensure the Wraparound Transition Plan is effective in the Client achieving and maintaining stabilization in the Family home.

b. Evaluation of the Wraparound Transition plan to occur at a frequency determined by the Client's needs and includes but is not limited to, visits to the Client's home, review of documentation, and coordination with other professionals and/or members of the Wraparound Transition Support Team to determine progress.

c. Reviews of the Client's stability and monitoring of Predictive Risk Factors that could indicate a return to Crisis.

d. Revision of the Wraparound Plan as needed to avert a Crisis or Crisis escalation.

e. Ensuring that follow-up appointments are made and kept.

6. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the Client, their family, and their Wraparound Transition Team.

7. All service providers and supports on the Wraparound Transition Team must adhere to the Wraparound Transition Plan.

8. Revision of strategies should be a continuous process by the Wraparound Transition Team in collaboration with the Client, until stabilization is achieved and there is no longer a need for Transition Support Services.

9. On-going evaluation after completion of the Wraparound Transition Plan may be provided based on individual needs to support the Client and their family in connecting to any additional resources needed to prevent future Crisis or out of home placement.

8.508.101 USE OF RESTRAINTS

A. The definitions contained at 12 CCR 2509-8; Section~~§~~ 7.714.1 (2019) are hereby incorporated by reference. The definition for "Client Representative" in 12 CCR 2509-8, Section.7.714.1 is specifically excluded. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to ~~C.R.S. §~~Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

B. Service Providers shall comply with the requirements for the use of Restraints in 12 CCR 2509-8,~~:~~ ~~§§~~ Sections 7.714.53 through 7.714.537, (2019) which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to ~~C.R.S. §~~Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated

text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

C. All records of restraints shall be reviewed by a supervisor of the Service Provider within 24 hours of the incident. If it appears that the Client has been restrained excessively, frequently in a short period of time, or frequently by the same staff member, the Client's Service Plan must be reviewed.

8.508.102 RIGHTS MODIFICATIONS

A. Cruel and aversive therapy, or cruel and unusual discipline is prohibited.

B. Service Providers shall comply with the requirements for Client Rights in 12 CCR 2509-8; ~~§~~Section 7.714.52 (2019) ~~which are~~is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. ~~§~~ Section 24-4-103(12.5) C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

C. Rights modifications are based on the specific assessed needs of the child or youth, not the convenience of the provider.

D. Rights modifications may only be imposed if the Client poses a danger to self, Family, and/or the community.

E. The case manager is responsible for obtaining Informed Consent and other documentation supporting any rights modifications/limitations and must maintain these materials in their file as a part of the Service Plan.

F. Any rights modification must be supported by a specific assessed need and justified in the Service Plan. The following must be documented in the Service Plan:

1. Identification of a specific and individualized need.

2. Documentation of the positive interventions and supports used prior to any modifications Service Plan.

3. Documentation of less intrusive methods of meeting the Client's needs that have been tried, and the outcome.

4. A description of the rights modification to be used that is directly proportionate to respond to the specific assessed need.

5. The collection and review of data used to measure the ongoing effectiveness of the modification.

6. Established time limits for periodic reviews, no less than every six (6) months, to determine if the modification is still necessary or if it can be terminated.

7. The Informed Consent of the Individual.

8. An assurance that interventions and Support will cause no harm to the Individual.

G. Specialized Group Facilities, Foster Care Homes, Kinship Foster Care Home, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours), and Child Placement

Agencies must also ensure compliance with the Colorado Department Human Services rules regarding the use of restrictive interventions at 12 CCR 2509-8.

8.508.103 MEDICATION ADMINISTRATION

A. If medications are administered during the course of HCBS-CHRP service delivery by the waiver service provider, the following shall apply:

1. Medications must by prescribed by a Licensed Medical Professional. Prescriptions and/or orders must be kept in the Client's record.

2. HCBS-CHRP waiver service providers must complete on-site monitoring of the administration of medications to waiver participants including inspecting medications for labeling, safe storage, completing pill counts, reviewing and reconciling the medication administration records, and interviews with staff and participants.

3. Specialized Group Facilities, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours) must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; ~~§~~ Section 7.702.52 (C).

4. Foster Care Homes and Kinship Foster Care Homes must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; Section ~~§~~708.41.J.

5. Persons administering medications shall complete a course in medication administration through an approved training entity approved by the Colorado Department of Public Health and Environment.

8.508.110 MAINTENANCE OF CASE RECORDS

A. CMAs shall maintain all documents, records, communications, notes and other materials for all work performed related to HCBS-CHRP. CMAs shall maintain records for six (6) years after the date a Client discharges from a waiver program.

8.508.121 REASSESSMENT AND REDETERMINATION OF ELIGIBILITY

A. The CMA shall conduct a Level of Care Evaluation and Determination to redetermine or confirm a Client's eligibility for the HCBS-CHRP waiver, at a minimum, every twelve (12) months.

B. The CMA shall conduct a Comprehensive Assessment to redetermine or confirm a Client's individual needs, at a minimum, every twelve (12) months.

C. The CMA shall verify that the child or youth remains Medicaid Eligible at a minimum, every twelve (12) months.

8.508.140 DISCONTINUATION FROM THE HCBS- CHRP WAIVER

A. A Client shall be discontinued from the HCBS-CHRP waiver when one of the following occurs:

1. The Client no longer meets the criteria set forth in S~~s~~ection 8.508.40;

2. The costs of services and supports provided in the community exceed the Cost Effectiveness exceeds ICF-IID costs;

3. The Client enrolls in another HCBS waiver program or is admitted for a long-term stay beyond 30 consecutive days in an Institution; or

4. The Client reaches his/her 21st birthday.

5. The Client does not receive a waiver service during a full one-month period.

8.508.160 SERVICE PROVIDERS

A. Service providers for habilitation services and services provided outside the Family home shall meet all of the certification, licensing and quality assurance regulations related to their provider type (Respite Service providers that provide supported community connection, movement therapy, massage therapy, hippotherapy, intensive support, and transition support in the family home must:

1. Meet the required qualifications as defined in the federally approved HCBS-CHRP waiver.

2. Maintain and abide by all the terms of their Medicaid Provider Agreement and section 8.130.

3. Comply with all the provisions of this Ssection 8.508; and

4. Have and maintain any required state licensure.

B. Service providers shall maintain liability insurance in at least such minimum amounts as set annually by the Department.

C. A Family member may not be a Service Agency for another Family member. A Family member may be reimbursed for certain services as approved in the waiver.

D. Service Providers shall not discontinue or refuse services to a Client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

E. Service Providers must have written policies that address the following:

1. Access to duplication and dissemination of information from the child's or youth's records in compliance with all applicable state and federal privacy laws.

2. How to response to alleged or suspected abuse, mistreatment, neglect, or exploitation. The policy must require immediate reporting when observed by employees and contractors to the agency administrator or designee and include mandatory reporting requirements pursuant to Ssections 19-3-304 , C.R.S. and 18-6.5-108, C.R.S.

3. The use of restraints, the rights of Client's, and rights modifications pursuant to Ssections 8.508.101 and 8.508.102.

4. Medication administration pursuant to Section 8.508.103.

5. Training employees and contractors to enable them to carry out their duties and responsibilities efficiently, effectively and competently. The policy must include staffing ratios that are sufficient to meet the individualized support needs of each Client receiving services.

6. Emergency procedures including response to fire, evacuation, severe weather, natural disasters, relocation, and staffing shortages.

F. Service Provides must maintain records to substantiate claims for reimbursement in accordance with Department regulations and guidance.

G. Service Providers must comply with all federal and state program reviews and financial audits of HCBS-CHRP waiver services.

H. Service Providers must comply with requests by the Department to collect, review, and maintain individual or agency information on the HCBS-CHRP waiver.

I. Service Providers must comply with requests by the CMA to monitor service delivery through Targeted Case Management.

8.508.165 TERMINATION OR DENIAL OF HCBS-CHRP MEDICAID PROVIDER AGREEMENTS

A. The Department may deny or terminate an HCBS-CHRP waiver Medicaid provider agreement in accordance with ~~§~~Section 8.076.5.

8.508.180 CLIENT'S RIGHTS

A. Service Providers shall comply with the requirements for Client's Rights in 12 CCR 2509-8; ~~§~~ Section 7.714.31 (2019) which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to ~~C.R.S. §~~Section 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. Copies of incorporated materials are provided at cost upon request.

B. Every Client has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, gender identity, political affiliation, sexual orientation, financial status or disability.

C. Every Client has the right to access age appropriate forms of communication including text, email, and social media.

D. No Client, his/her Family members, Guardian or Client Representative may be retaliated against in their receipt of services or supports as a result of attempts to advocate on their own behalf.

E. Each Client receiving services has the right to read or have explained in each Client's and Family's native language, any policies and/or procedures adopted by the Service Agency.

8.508.190 APPEALS

A. The CCB shall provide a Long-Term Care notice of action form (LTC 803) to Applicants and Clients and their parent(s) or Guardian in accordance with section 8.057 when:

1. The Applicant is determined not to have a developmental delay or developmental disability,

2. The Applicant is determined eligible or ineligible for Long-Term Services and Supports (LTSS),

3. The Applicant is determined eligible or ineligible for placement on a waiting list for LTSS services,

4. An Adverse Action occurs that affects the Client's waiver enrollment status.

B. The CCB shall appear and defend its decision at the Office of Administrative Courts.

C. The CCB shall notify the Case Management Agency in the Client's Service Plan within one (1) business day of the Adverse Action.

D. The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business days of an Adverse Action that affects Medicaid financial eligibility.

E. The CCB shall notify the applicant's parent or Guardian of an Adverse Action if the applicant or Client is determined ineligible for any reason including if:

1. The Client is detained or resides in a correctional facility for at least one day, and

2. The Client enters an institute for mental health for a duration greater than thirty (30) days.

F. The CMA shall provide the Long-Term Care notice of action form to Clients in accordance with section 8.507 when:

1. An Adverse Action occurs that affects the Client's waiver services, or

G. The CMA shall notify all providers in the Client's Service Plan within one (1) business days of the Adverse Action.

1. The CMA shall notify the county Department of Human/Social Services income maintenance technician within ten (10) business days of an Adverse Action that may affect financial eligibility for HCBS waiver services.

H. The applicant or Client shall be informed of an Adverse Action if the applicant or ~~client~~Client is determined to be ineligible as set forth in the waiver- specific Client eligibility criteria and the following:

1. The Client cannot be served safely within the Cost Containment identified in the HCBS waiver,

2. The Client is placed in an Institution for treatment for more than thirty (30) consecutive days,

3. The Client is detained or resides in a correctional facility for at least one day, or

4. The Client enters an institute for mental health for more than thirty (30) consecutive days.

I. The Client shall be notified, pursuant to section 8.057.2. when the following results in an Adverse Action that does not relate to waiver ~~client~~Client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the Level of Care Evaluation and Determination

2. A Service Plan or waiver service exceeds the limits set forth in the federally approved waiver.

3. The Client is being terminated from HCBS due to a failure to attend a Level of Care assessment appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

4. The Client is being terminated from HCBS due to a failure to attend a Service Plan appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

5. The Client enrolls in a different LTSS program.

6. The Client moves out of state. The Client shall be discontinued effective the day after the date of the move.

    a. A Client who leaves the state on a temporary basis, with intent to return to Colorado, pursuant to Section 8.100.3.B.4, shall not be terminated unless one or more of the Client eligibility criteria are no longer met.

J. If a Client voluntarily withdraws from the waiver, the termination shall be effective the day after the date the s the request was made by the Client

    1. The case manager shall review with the Client their decision to voluntarily withdraw from the waiver. The Case Manager shall not send a notice of action, upon confirmation of withdraw.

K. The CMA shall not send a Long-Term Care notice of action form when the basis for termination is death of the Client but shall document the event in the Client record. The date of action shall be the day after the date of death.

L. The CMA shall appear and defend its decision at the Office of Administrative Courts when the CMA has issued an Adverse Action.

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

8.509.10 GENERAL PROVISIONS

8.509.11 LEGAL BASIS

A. The Home and Community- -bBased Services for COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS) program in Colorado is authorized by a waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CMHS program is also authorized under state law at Sections 25.5-6-601 through 25.5-6-607, C.R.S. The number of recipients served in the HCBS-CMHS program is limited to the number of recipients authorized in the waiver.

B. All congregate facilities where any HCBS ~~client~~Client resides~~,~~ must be in possession of a valid Assisted Living Residence license issued under Section 25-27-105, C.R.S., and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7.

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

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

1. Adult Day Services
2. Alternative Care Services (which includes Homemaker and Personal Care services)
3. Consumer Directed Attendant Support Services (CDASS)
4. Electronic Monitoring
5. Home Delivered Meals
6. Home Modification
7. Homemaker Services
8. Life Skills Training (LST)
9. Non-Medical Transportation
10. Peer Mentorship
11. Personal Care
12. Respite Care
13. Transition Setup

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

C. HCBS-CMHS ~~client~~Clients are eligible for all other Medicaid State plan benefits.

8.509.13 DEFINITIONS OF SERVICES

A. Adult Day Services is defined at Section 8.491.

B. Alternative Care Services is defined at Section 8.495.1.

C. Consumer Directed Attendant Support Services (CDASS) is defined at Section 8.510.1.

D. Electronic Monitoring services is defined at Section 8.488.11.

E. Home Delivered Meals is defined at Section 8.553.1.

F. Home Modification is defined at Section 8.493.1.

G. Homemaker Services is defined at Section 8.490.1.

H. Life Skills Training (LST) is defined at Section 8.553.1.

I. Non-Medical Transportation is defined at Section 8.494.1.

J. Peer Mentorship is defined at Section 8.553.

K. Personal Care is defined at Section 8.500.94.B.12.

L. Respite is defined at Section 8.492.

M. Transition Setup is defined at Section 8.553.

8.509.14 GENERAL DEFINITIONS

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

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

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

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

E. Categorically Eligible, shall be defined in the HCBS-CMHS Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the ~~client~~Client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-CMHS as three hundred percent eligible persons, as defined at 8.509.14.S.

F. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for

independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

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

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

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

J. Department shall be defined as the State Agency designated as the Single State Medicaid Agency for Colorado, or another state agency operating under the authority of a memorandum of understanding with the Single State Medicaid Agency.

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

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

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

N. Intake/Screening/Referral shall be as defined at Section 8.390.1(M) and as the initial contact with ~~client~~Clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for ~~long term~~long-term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive ~~long term~~long-term care ~~client~~Client assessment.

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

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

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

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

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

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

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

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

8.509.15 ELIGIBLE PERSONS

A. HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

Clients shall meet the eligibility criteria as specified in ~~the Income Maintenance Staff Manual of the Colorado Department of Human Services at~~ 9 CCR 2503-~~1~~5, and the ~~Colorado Department of Health Care Policy and Finacning regulations at 10 CCR 2505-10,~~ Section 8.100~~, MEDICAL ASSISTANCE ELIGIBILITY~~.

2. Level of Care AND Target Group.

Clients who have been determined to meet the level of care AND target group criteria shall be certified by the Utilization Review ~~Committee~~ Contractor (URC) as functionally eligible for HCBS-CMHS. The URC shall only certify HCBS-CMHS eligibility for those ~~client~~Clients:

a. Determined to meet the target group definition, defined as a person experiencing a severe and persistent mental health need that requires assistance with one or more Activities of Daily Living (ADL);

i. A person experiencing a severe and persistent mental health need is defined as someone who:

1) Is 18 years of age or older with a severe and persistent mental health need; and

2) Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM -5); and

a) Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and

b) Has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

ii. A severe and persistent mental health need does not include:

1) Intellectual or developmental disorders; or

2) Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.

b. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11-15; and

c. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.

3. Receiving Services

a. Only ~~client~~Clients who receive HCBS-CMHS services, or who have agreed to accept HCBS-CMHS services as soon as all other eligibility criteria have been met, are eligible for the HCBS-CMHS program.

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

c. Desire or need for home health services or other Medicaid services that are not HCBS-CMHS services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.

d. HCBS-CMHS ~~client~~Clients who have not received HCBS-CMHS services for thirty (30) days shall be discontinued from the program.

4. Institutional Status

a. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-CMHS services while residing in such institutions.

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

c. A ~~client~~Client who is already an HCBS-CMHS recipient and who enters a nursing facility may not receive HCBS-CMHS services while in the nursing facility;

1) The case manager must terminate the ~~client~~Client from the HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ULTC-100.2 for the nursing facility placement, as verified by telephoning the URC.

2) A ~~client~~Client receiving HCBS-CMHS services who enters a nursing facility for Respite Care as a service under the HCBS-CMHS program shall not be required to obtain a nursing facility ULTC-100.2, and shall be continued as an HCBS-CMHS ~~client~~Client in order to receive the HCBS-CMHS service of Respite Care in a nursing facility.

5. Cost-effectiveness

Only ~~client~~Clients who can be safely served within cost containment, as defined at Section 8.509.14 (I), are eligible for the HCBS-CMHS program. The equivalent cost of nursing facility care is calculated by the State, according to Section 8.509.19.

8.509.16 START DATE

The start date of eligibility for HCBS-CMHS services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which HCBS-CMHS services can be reimbursed shall be the LATER of any of the following:

A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care This date is determined by the official ~~URC stamp and the~~ URC-assigned start date on the ULTC 100.2 form.

C. Receiving Services This date shall be determined by the date on which the ~~client~~Client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept HCBS-CMHS services.

D. Institutional Status HCBS-CMHS eligibility cannot precede the date of discharge from the hospital or nursing facility.

8.509.17 CLIENT PAYMENT OBLIGATION - POST ELIGIBILITY TREATMENT OF INCOME (PETI)

When a ~~client~~Client has been determined eligible for Home and Community-~~b~~Based Services (HCBS) under the 300% income standard, according to Section 8.100, of Staff Manual Volume 8, the State may reduce Medicaid payment for Alternative Care Facility services according to the procedures at Section 8.509.31, E, of Staff Manual Volume 8.

8.509.18 STATE PRIOR AUTHORIZATION OF SERVICES

A. Upon receipt of the Prior Authorization Request (PAR), as described at Section 8.509.31(G), the state or its agent shall review the PAR to determine whether it is in compliance with all applicable regulations, and whether services requested are consistent with the ~~client~~Client's documented medical condition and functional capacity, and are reasonable in amount, frequency, and duration. Within ten (10) working days the State or its agent shall:

1. Approve the PAR and forward signed copies of the prior authorization form to the case management agency, when all requirements are met;

2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear, or incorrect; or if services requested are not adequately justified;

3. Disapprove the PAR when all requirements are not met Services shall be disapproved that are duplicative of other services that the ~~client~~Client is receiving or services for which the ~~client~~Client is receiving funds to purchase Services shall also be disapproved if all services, regardless of funding source, total more than twenty-four hours per day care.

B. When services are disapproved, in whole or in part the Department or its agent shall notify the case management agency. The case management agency shall notify the ~~client~~Client of the adverse action and the appeal rights on a state-prescribed form, according to Section 8.057, et seq.

C. Revisions received by the Department or its agent six (6) months or more after the end date shall always be disapproved.

D. Approval of the PAR by the Department or its agent shall authorize providers of services under the case plan to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the ~~client~~Client's financial eligibility for ~~long term~~long-term care medical assistance (Medicaid) on the dates of service; and upon providers' use of correct billing procedures.

8.509.19 STATE CALCULATION OF COST-CONTAINMENT AMOUNT

A. The State shall annually compute the equivalent monthly cost of nursing facility care according to Section 8.485.100.

B. LIMITATIONS ON PAYMENT TO FAMILY

1. With the exception of Consumer Directed Attendant Support Service, i~~I~~n no case shall any person be reimbursed to provide HCBS-CMHS services to his or her spouse.

2. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-CMHS program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the ~~client~~Client by virtue of blood, marriage, adoption or common law.

3. The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.

4. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

a. ~~The total number of Medicaid personal care units for a member of the client's family shall not exceed the equivalent of 444 personal care units~~ hours ~~per annual certification for HCBS-CMHS.~~ The maximum number of personal care units per annual certification for HCBS-CMHS shall be the equivalent of 444 hours. Family members must average at least 1.2164 hours of care per day (as indicated on the Client's care plan) in order to receive the maximum reimbursement.

b. The maximum shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision and all other administrative costs.

~~c. The maximum number of personal care units per annual certification for HCBS-CMHS shall be 444 units~~hours~~. Family members must average at least 1.2164 hours of care per day (as indicated on the client's care plan) in order to receive the maximum reimbursement.~~

c~~d~~. If the certification period for HCBS-CMHS is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the ~~client~~Client is receiving care by the average units per day for a full year (444/365=1.2164).

5. If two or more HCBS-CMHS ~~client~~Clients reside in the same household, family members may be reimbursed up to the maximum for each ~~client~~Client if the services are not duplicative and are appropriate to meet the ~~client~~Client's needs.

6. When HCBS-CMHS funds are utilized for reimbursement of personal care services provided by the ~~client~~Client's family, the home care allowance cannot be used to reimburse the family.

7. Services other than personal care or Consumer Directed Attendant Support Services shall not be reimbursed with the HCBS-CMHS funds when provided by the ~~client~~Client's family.

~~8. Services other than personal care shall not be reimbursed with the HCBS-CMHS funds when provided by the client's family.~~

C. CLIENT RIGHTS

1. The case manager shall inform ~~client~~Clients eligible for HCBS-CMHS in writing, of their right to choose between HCBS-CMHS services and nursing facility care; and

2. The case manager shall offer ~~client~~Clients eligible for HCBS-CMHS, the free choice of any and all available and qualified providers of appropriate services.

8.509.20 CASE MANAGEMENT AGENCIES

A. The requirement at Section 8.390 et. seq. shall apply to the case management agencies performing the case management functions of the HCBS-CMHS program.

8.509.21 CERTIFICATION

A. Case management agencies shall be certified, monitored and periodically recertified as required in Section 8.394 et. seq.

B. Case management agencies must have provider agreements with the Department that are specific to the HCBS-CMHS program.

8.509.22 REIMBURSEMENT

Case management agencies shall be reimbursed for case management activities according to Section 8.392 et. seq.

8.509.30 CASE MANAGEMENT FUNCTIONS

8.509.31 NEW HCBS-CMHS CLIENTS

A. INTAKE/SCREENING/REFERRAL

1. Case management agency staff shall complete a State-prescribed Intake form in accordance with the Single Entry Point Intake Procedures at Section 8.393.2~~1~~ for each potential HCBS-CMHS applicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the applicant for purposes of establishing a start date. Additionally, at intake, ~~client~~Clients shall be offered an opportunity to identify a third party to receive ~~client~~Client notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to ~~client~~Clients.

2. Case management agency staff shall verify the individual's current financial eligibility status~~,~~ or refer the ~~client~~Client to the county department of social services of the ~~client~~Client's county of residence for application. This verification shall include whether

the applicant is in a category of assistance that includes financial eligibility for ~~long term~~long-term care.

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long-~~-~~term care C~~c~~lient assessment (ULTC-100.2), and shall explain the reasons for the decision on the Intake form. The ~~client~~Client shall be informed of the right to request an assessment if the ~~client~~Client disagrees with the case manager's decision.

4. If the case management agency staff has determined that a comprehensive uniform ~~long term~~long-term care client assessment (ULTC-100.2) is needed, or if the ~~client~~Client requests an assessment, a case manager shall be assigned to schedule the assessment.

B. ASSESSMENT

1. The URC/SEP case manager shall complete the Uniform ~~Long Term~~Long-term Care Client Assessment Instrument (ULTC 100.2) in accordance with Section 8.393.2~~2~~, ASSESSMENT.

2. The URC/SEP case manager shall begin and complete the assessment within ten (10) days of notification of ~~client~~Client's need for assessment.

3. The URC/SEP case manager shall complete the following activities for a comprehensive client assessment:

   a. Obtain all required information from the ~~client~~Client's medical provider including information required for target group determination;

   b. Determine the ~~client~~Client's functional capacity during a face-to-face interview, preferably with the observation of the ~~client~~Client in his or her residential setting. Upon Department approval, the assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.).;

   c. Determine the ability and appropriateness of the ~~client~~Client's caregiver, family, and other collateral, to provide the ~~client~~Client assistance in activities of daily living;

   d. Determine the ~~client~~Client's service needs, including the ~~client~~Client's need for services not provided under HCBS-CMHS

   e. If the ~~client~~Client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;

   f. Review service options based on the ~~client~~Client's needs, the potential funding sources, and the availability of resources;

   g. Explore the ~~client~~Client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;

   h. View and document the current Assisted Living Residence license, if the ~~client~~Client lives, or plans to live, in a congregate facility as defined at Section 8.509.14in order to assure compliance with the regulation at Section 5.509.11(B).

i. Determine and document ~~client~~Client preferences in program selection;

j. Complete documentation on the ULTC 100.2 form.

k. To de-institutionalize a ~~client~~Client who is in a nursing facility under payment by Medicaid, and with a current ULTC 100.2 already certified by the URC/SEP agency for the nursing facility level of ULTC 100.2 completion date is older than six (6) months, the URC/SEP case manager shall complete a new ULTC 100.2 and determine if the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-CMHS, the case manager must obtain a new ULTC 100.2 and the ~~client~~Client shall be treated as an applicant from the community rather than as a de-institutionalized ~~client~~Client.

l. It is the URC/SEP case manager's responsibility to assess the behaviors of the ~~client~~Client and assure that community placement is appropriate.

C. HCBS-CMHS DENIALS AND/OR DISCONTINUATIONS

1. If a ~~client~~Client is determined, at any point in the assessment process, to be ineligible for HCBS-CMHS according to any of the requirements at Section 8.509.15, the case manager shall refer the ~~client~~Client or the ~~client~~Client's designated representative to other appropriate services. Clients who are denied HCBS-CMHS services shall be notified of denials and appeal rights as follows:

a. Financial Eligibility

The income maintenance technician at the county department of social services shall notify the applicant of denial for reasons of financial eligibility~~,~~ and shall inform the applicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.

b. Level of Care AND Target Group

The URC shall notify the applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the applicant of appeal rights in accordance with Section 8.057. The case manager shall not make judgments as to eligibility regarding level of care or target group, and shall refer all applicants who request a URC review to the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.

c. Receiving Services

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determines that the applicant does not meet the HCBS-CMHS eligibility requirements at Section 8.509.15 and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager

shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

d. Institutional Status

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement at Section 8.509.15~~,~~ and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

e. Cost-effectiveness

The case manager shall notify the applicant of denial, on State-prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement 8.509.15 and shall inform the applicant of appeal rights in accordance with Section 8.057, et.seq. The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available~~,~~ and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-CMHS eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the ~~client~~Client's physician attesting to the ~~client~~Client's mental competency status, and all other available information which will support the determination that the ~~client~~Client is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the URC in regard to level of care and target group determination.

f. Waiver Cap

The case manager shall notify the applicant of denial, on a State-prescribed form, when the waiver cap limiting the number of ~~client~~Clients who may be served under the terms of the approved waiver has been reached.

D. SERVICE PLANNING

1. Service Planning shall be defined in accordance with case planning at Section 8.393.2~~3~~ and shall include, but not be limited to, the following tasks:

a. The identification and documentation of service plan goals and ~~client~~Client choices;

b. The identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, finding source, and services needed but not available;

c. Documentation of the ~~client~~Client's choice of HCBS-CMHS services, nursing home placement, or other services, including a physical or digitally signed statement of choice from the ~~client~~Client;

d. Documentation that the ~~client~~Client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the ~~client~~Client understands his/her right to change providers;

e. The formalization of the service plan agreement on a State-prescribed service plan form, including appropriate physical or digital signatures;

f. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the ~~client~~Client regarding service provision;

g. Referral to community resources as needed and development of resources for individual ~~client~~Clients if a resource is not available within the ~~client~~Client's community;

h. The explanation of complaint procedures to the ~~client~~Client.

2. The case manager shall meet the ~~client~~Client's needs, with consideration of the ~~client~~Client's choices, using the most cost-~~-~~effective methods available.

E. CALCULATION OF CLIENT PAYMENT (PETI)

1. The case manager shall calculate the ~~client~~Client payment (PETI) for 300% eligible HCBS-CMHS ~~client~~Clients according to the following procedures:

a. For 300% eligible HCBS-CMHS ~~client~~Clients who are not Alternative Care Facility ~~client~~Clients, the case manager shall allow an amount equal to the 300% standard as the ~~client~~Client maintenance allowance. No other deductions are necessary and no form is required to be completed.

b. For 300% eligible ~~client~~Clients who are Alternative Care Facility ~~client~~Clients, the case manager shall complete a State-prescribed form which calculates the ~~client~~Client payment according to the following procedures:

1) An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the ~~client~~Client's gross income to be used as the ~~client~~Client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid: and

2) For an individual with financial responsibility for only a spouse, an amount equal to the state Aid to the Needy Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the ~~client~~Client's gross income: or

3) For an individual with financial responsibility for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding income from part-time employment earnings of a dependent child who is either a full-time student of a part-time student as

defined at Section 8.100.3.L.2.d.) shall be deducted from the ~~client~~Client's gross income; and

4) Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the ~~client~~Client's gross income as follows:

a) Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS: deductible or co-insurance charges: and

b) Necessary dental care not to exceed amounts equal to actual expenses incurred: and

c) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred: and

d) Medications, with the following limitations:

(1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

(2) Medications which may be purchased with the ~~client~~Client's Medical Identification Card shall not be allowed as deductions.

(3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

(4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

(5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

e) Other necessary medical or remedial care shall be deducted from the ~~client~~Client's gross income, with the following limitations:

(1) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.

(2) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

f) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

g) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

5) Any remaining income-shall be applied to the cost of the Alternative Care Facility services, as defined at Section 8.495, and shall be paid by the ~~client~~Client directly to the facility; and

6) If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the ~~client~~Client's income, the remaining income shall be kept by the ~~client~~Client and may be used as additional personal needs or for any other use that the ~~client~~Client desires, except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services.

2. Case managers shall inform HCBS-CMHS Alternative Care Facility ~~client~~Clients of their ~~client~~Client payment obligation on a form prescribed by the state at the time of the first assessment visit by the end of each plan period; or within ten (10) working days whenever there is a significant change in the ~~client~~Client payment amount Significant change is defined as fifty dollars ($50) or more. Copies of ~~client~~Client payment forms shall be kept in the ~~client~~Client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request, according to Section 8.509.31.G, or if requested by the state for monitoring purposes.

F. COST CONTAINMENT

The case manager shall determine whether the person can be served at or under the cost containment criteria of Section 8.509.14(I) for ~~long term~~long-term care services for an individual recipient by using a state-prescribed Prior Authorization Request (PAR) form to:

1. Determine the maximum authorized costs for all HCBS-CMHS services for the period of time covered by the case plan and compute the average cost per day by dividing by the number of days in we case plan period; and

2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:

a. Enter (in the designated space on the PAR form) the average monthly cost of nursing facility care; and

b. Subtract from that amount the ~~client~~Client's gross monthly income: and

c. Subtract from that amount the ~~client~~Client's Home Care Allowance grant amount, if any: and

d. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount which cannot be exceeded for the cost of HCBS services.

3. An individual ~~client~~Client whose service needs exceed the amount allowed under the ~~client~~Client's individual cost containment amount may choose to purchase additional services with personal income, but no ~~client~~Client shall be required to do so.

G. PRIOR AUTHORIZATION REQUESTS

1. The case manager shall ~~submit~~ complete and submit a prior authorization request~~s~~ (PAR~~s~~) for all HCBS-CMHS services to the state or its agent in a timely manner in accordance with the STATE PRIOR AUTHORIZATION OF SERVICES in Section 8.485.90.

~~2. Every PAR shall include the Long Term Service Plan form; the Prior Approval Request form; the Uniform Long Term Care Client Assessment (ULTC 100.2) form; and written documentation, from the income maintenance technician or the eligibility system, of the client's current monthly income. All units of service requested on the Prior Approval Request form must be listed on the Long Term Service Plan form. If a range of units is estimated on the Long Term Service plan, the number of units at the higher end of the range may be requested on the Prior Approval Request form. "PRN" services must be given a numerical estimate on the Long Term Care plan.~~

~~3. If a PAR is for a new admission, or a re-admission, the Intake form shall be included with the PAR.~~

2~~4~~. If a PAR includes a request for home modification services, the PAR shall also include all documentation listed at Section 8.493, HOME MODIFICATION.

3~~5~~. If a PAR is for an Alternative Care Facility ~~client~~Client who is 300% eligible, the most recent state-prescribed Client Payment form shall be included in the PAR. All medical and remedial care requested as deductions on the Client Payment form must be listed on the long-term~~LONG TERM~~l Service Plan form.

4~~6~~. The start date on the prior authorization request form shall never precede the start date of eligibility for HCBS-CMHS services, according to Section 8.509.16, START DATE.

5~~7~~. The PAR shall not cover a period of time longer than the length of stay assigned by the URC.

6~~8~~. A PAR does not have to be submitted for a non-diversion, as defined at 8.509.14(O).

7~~9~~. If a PAR is returned to the case management agency for corrections, the corrected PAR must be returned to the State or its agent within thirty (30) calendar days after the case management agency receives the "Return to Provider" letter.

H. CASE MANAGEMENT AGENCY RESPONSIBILITY

1. The case management agency shall be financially responsible for any services which it authorized to be provided to the ~~client~~Client, or which continue to be rendered by a provider due to the case management agency's failure to timely notify the provider that the ~~client~~Client was no longer eligible for services, which did not receive approval by the state or its agent.

8.509.32 ONGOING HCBS-CMHS CLIENTS

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS ~~client~~Clients shall be in accordance with ~~ON-GOING CASE MANAGEMENT in~~ Section 8.393.2~~4~~. In addition, the case manager shall:

   a. Contact each ~~client~~Client quarterly, or more frequently, as determined by the ~~client~~Client's assessed needs. Contact may be at the ~~client~~Client's place of residence, by telephone, or other appropriate setting as determined by the ~~client~~Client's needs.

   b. Review the ULTC.100.2 and the Service Plan with the client every six (6) months on a face-to-face basis. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.).

2. The case manager shall refer the ~~client~~Client for mental health services taking into account ~~client~~Client choice. The case manager shall coordinate case management activities for those ~~client~~Clients who are receiving mental health services from the Behavioral Health Organizations (BHO).

3. On-going case management shall include, but not be limited to the following tasks:

   a. Review of the ~~client~~Client's case plan and service agreements;

   b. Contact with the ~~client~~Client concerning whether services are being delivered according to the plan; and the ~~client~~Client's satisfaction with services provided;

   c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;

   d. Contact with appropriate parties in the event any issues or complaints have been presented by the ~~client~~Client or others;

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

   f. Informal assessment of changes in ~~client~~Client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;

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

   h. Referral to community resources, and arrangement for non-HCBS-CMHS services, as needed.

4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or mis-utilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

B. REVISIONS

1. SERVICES ADDED TO THE SERVICE PLAN

a. Whenever a change in the service plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the state or its agent.

1) The revision PAR shall include the revised Long-t-Term Care plan form and the revised Prior Authorization Request form.

2) The revised service plan form shall list the services being revised and shall state the reason for the revision. Services on the revised service plan form, plus all services on the original service plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.

3) The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.

b. If a revised PAR includes a new request for home modification services, the revised PAR shall also include all documentation listed at Section 8.493.

2. SERVICES DECREASED ON THE SERVICE PLAN

~~a. A revised PAR does not need to be submitted if services on the service plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness~~

ab. If services are decreased without the ~~client~~Client's agreement according to Section 8.057.5, the case manager shall notify the ~~client~~Client of the adverse action and of appeal rights, according to Section 8.057, et. seq.

C.REASSESSMENT

1. The case manager shall complete a reassessment of each HCBS-CMHS ~~client~~Client before the end of the length of stay assigned by the URC at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect HCBS-CMHS eligibility.

2. The case manager shall complete the reassessment, utilizing the Uniform Long-t-Term Care Client Assessment Instrument (ULTC 100.2).

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

a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for ~~long term~~long-term care benefits;

b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;

c. Evaluate continuing need for the HCBS-CMHS program, and clearly document reasons for continuing HCBS; or terminate the ~~client~~Client's eligibility according to Section 8.509.32(E);

d. Ensure that all information needed from the medical provider for the URC level of care review is included on the ULTC 100.2 form;

e. Reassess the ~~client~~Client's functional status, according to the procedures in Section 8.509.31(B);

f. Review the case plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.509.31(D);

g. Refer the ~~client~~Client to community resources as needed;

h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31(G). For ~~client~~Clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ULTC 100.2. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the ~~client~~Client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Office of Administrative Courts to the ~~client~~Client; or (c) a copy of the notice of a scheduled court date.

Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed~~,~~ and shall not be accepted as a substitute for the approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

D. TRANSFER PROCEDURES

1. When ~~client~~Clients move, cases shall be transferred according to the current statewide Mental Health Services Continuity of Care Policy.

2. INTERCOUNTY TRANSFERS shall be in accordance with Section 8.393.31.

3. INTERDISTRICT TRANSFERS shall be in accordance with Section 8.393.32.

E. TERMINATION

1. ~~Client~~Clients shall be terminated from the HCBS-CMHS program whenever they no longer meet one or more of the eligibility requirements at Section 8.509.15. Clients shall

also be terminated from the program if they die, move out of state or voluntarily withdraw from the program.

2. Clients who are terminated from HCBS-CMHS because they no longer meet one or more of the eligibility requirements at Section 8.509.15 shall be notified of the termination and their appeal rights as follows:

   a. Financial Eligibility

      Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason.

   b. Level of Care AND Target Group

      Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason.

   c. Receiving Services

      Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason

   d. Institutional Status

      Procedures at Section 8.509.31(C)~~,~~ shall be followed for terminations for this reason. In the case of termination for extended hospitalization, the case manager shall send the termination notice on the thirtieth (30) day of hospitalization. The termination shall he effective at the end of the advance notice period. If the ~~client~~Client returns home before the end of the advance notice period, the termination shall be rescinded.

   e. Cost-effectiveness

      Procedures at Section 8.509.31(C)~~,~~ shall be followed for terminations for this reason.

3. When ~~client~~Clients are terminated from HCBS-CMHS for reasons not related to ~~me~~ eligibility requirements at Section 8.509.31(C), the case manager shall follow the procedures below:

   a. Death

      Clients who die shall be terminated from the HCBS-CMHS program, effective upon the day after the date of death.

   b. Moved out of State

      Clients who move out of Colorado shall be terminated from the HCBS-CMHS program, effective upon the day after the date of the move. The case manager shall send the ~~client~~Client a state-prescribed Advisement Letter advising the ~~client~~Client that the case has been closed. Clients who leave the state on a temporary basis, with intent to return to Colorado, according to the Income Maintenance Staff Manual Section 1140.2, shall not be terminated from the HCBS-CMHS program unless one or more of the other eligibility criteria, as specified at Section 8.509.15 is no longer met.

c. Voluntary Withdrawal from the Program

Clients who voluntarily withdraw from the HCBS-CMHS program shall be terminated from the program, effective upon the day after the date on which the ~~client~~Client either requests in writing to withdraw from the program, or the date on which the ~~client~~Client enters a nursing facility. The case manager shall send the ~~client~~Client a state-prescribed Advisement Letter advising the ~~client~~Client that the case has been closed.

4. The case manager shall provide appropriate referrals to other community resources, as needed, upon termination.

5. The case manager shall immediately notify all providers on the case plan of any terminations.

6. If a case is terminated before an approved PAR has expired, the case manager shall submit, to the state or its agent, a copy of the current prior authorization request form, on which the end date is adjusted (and highlighted in some manner on the form); and the reason for termination shall be written on the form.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

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

1. The case manager shall inform the income maintenance technician of any and all changes in the ~~client~~Client's participation in HCBS-CMHS~~,~~ and shall provide the technician with copies of the first page of all URC-approved ULTC-100.2 forms.

2. The case manager shall inform all Alternative Care Facility ~~client~~Clients of their obligation to pay the full and current state-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

3. If the ~~client~~Client has an open service case file at the county department of social services, the case manager shall keep the ~~client~~Client's caseworker informed of the ~~client~~Client's status and shall participate in mutual staffing of the ~~client~~Client's case.

4. The case manager shall inform the ~~client~~Client's physician of any significant changes in the ~~client~~Client's condition or needs.

5. Within five (5) working days of receipt, from the State or it; agent, of the approved Prior Authorization Request form, the case manager shall provide copies to all the HCBS-CMHS providers in the case plan.

6. The case manager shall notify the URC, on a form prescribed by the state of the outcome of all non-diversions, as defined at Section 8.509.14.

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

8. The case management agency shall notify the state of any ~~client~~Client appeals which are initiated as a result of denials or terminations made by the case management agency.

B. CASE RECORDING/DOCUMENTATION

1. The case management agency shall maintain records on every individual for whom intake was conducted, including a copy of the intake form. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the case management agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.

2. The case record shall include:

   a. Identifying information, including the state identification (Medicaid) number, and

   b. All state-required forms; and

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

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

   a. A separate case record shall be maintained for each ~~client~~Client receiving services in the Home and Community- bBased Services for Community Mental Health Supports Program.

   b. Documentation shall be legible;

   c. Entries shall be written at the time of the activity or shortly thereafter,

   d. Entries shall be dated according to the date of the activity, including the year;

   e. Entries shall be made in permanent ink or digital signature;

   f. The ~~client~~Client shall be identified on every page;

   g. The person making each entry shall be identified;

   h. Entries shall be concise, but shall include all pertinent information;

   i. All information regarding a ~~client~~Client shall be kept together for easy access and review by case managers, supervisors, program monitors and auditors;

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

   k. All persons and agencies referenced in the documentation shall be identified by name and by relationship to the ~~client~~Client;

   l. All forms prescribed by the State shall be filled out by the case manager to be complete, correct and accurate.

   m. If the individual is unable to sign a form requiring his/her signature because of a medical condition, a digital signature or any mark ~~that~~ the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of

making a mark or performing a digital signature, the physical or digital signature of guardian or other authorized representative will be accepted.

4. All records shall be kept for the period of time specified in the case management agency contract, and shall be made available to the state as specified in the contract.

8.509.40 HCBS-CMHS PROVIDERS

A. Any provider agency with a valid contract to provide HCBS-EBD services, according to Section 8.487, shall be deemed certified to provide the same services to HCBS-CMHS ~~client~~Clients.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

A. Adaptive Equipment means one or more devices used to assist with completing activities of daily living.

B. Allocation means the funds determined by the Case Manager in collaboration with the ~~client~~Client and made available by the Department through the Financial Management Service (FMS) vendor for Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option.

C. Assessment means a comprehensive evaluation with the ~~client~~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~~Client's medical provider to determine the ~~client~~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.

D. Attendant means the individual who meets qualifications in 8.510.8 who provides CDASS as described in 8.510.3 and is hired by the ~~client~~Client or Authorized Representative through the contracted FMS vendor.

E. Attendant Support Management Plan (ASMP) means the documented plan described in 8.510.5, detailing management of Attendant support needs through CDASS.

F. Authorized Representative (AR) means an individual designated by the ~~client~~Client or the ~~client~~Client's legal guardian, if applicable, who has the judgment and ability to direct CDASS on a ~~client~~Client's behalf and meets the qualifications contained in 8.510.6 and 8.510.7.

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-~~B~~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.

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~~Client's functional eligibility for one or more Home and Community-~~B~~based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the ~~client~~Client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and periodic reassessment of ~~client~~Client needs.

I. Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that empowers ~~client~~Clients to direct their care and services to assist them in accomplishing activities

of daily living when included as a waiver benefit. CDASS benefits 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~~Client is approved to receive CDASS within the annual certification period.

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

L. CDASS Training means the required CDASS training and comprehensive assessment provided by the Training and Operations Vendor to a ~~client~~Client or Authorized Representative.

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

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

O. Financial Eligibility means the Health First Colorado financial eligibility criteria based on ~~client~~Client income and resources.

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

Q. Fiscal/Employer Agent (F/EA) provides FMS by performing payroll and administrative functions for ~~client~~Clients receiving CDASS benefits. The F/EA pays Attendants for CDASS services and maintains workers' compensation policies on the ~~client~~Client-employer's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both ~~client~~Client-employer and Attendant-employee Social Security and Medicare taxes.

R. Functional Eligibility means the physical and cognitive functioning criteria a ~~client~~Client must meet to qualify for a Medicaid waiver program, as determined by the Department's functional eligibility assessment tool.

S. ~~Home and Community-Based Services~~Home and Community-based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to ~~client~~Clients in community settings. These services are designed to help older persons and persons with disabilities to live in the community.

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.

U. Licensed Medical Professional means the primary care provider of the ~~client~~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.

V. Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the ~~client~~Client.

W. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web site, ~~client~~Client account statements, Case Manager contact, or FMS vendor contact.

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

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 ~~client~~Clients, Authorized Representatives, and Case Managers.

8.510.2 ELIGIBILITY

8.510.2.A. To be eligible for the CDASS delivery option, the ~~client~~Client shall meet the following eligibility criteria:

1. Choose the CDASS delivery option.

2. Meet HCBS waiver functional and financial eligibility requirements.

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

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

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

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

    a. ~~Client~~Client training obligations

        i. ~~Client~~Clients and ARs 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~~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~~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 COVERED SERVICES

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

8.510.3.B. Services include:

1. Homemaker: General household activities provided by an Attendant in a ~~client~~Client's home to maintain a healthy and safe environment for the ~~client~~Client. Homemaker activities shall be provided only in the primary living space of the ~~client~~Client and multiple Attendants may not be reimbursed for duplicating homemaker tasks. Tasks may include the following activities or teaching the following activities:

    a. 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: Services furnished to an eligible ~~client~~Client in the community or in the ~~client~~Client's home to meet the ~~client~~Client's physical, maintenance, and supportive needs. 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 distilled water reservoirs, and moving a cannula or mask from or to the ~~client~~Client's face;

    c. Preventive 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~~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 and 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~~Client is able to assist or direct.

g. Transferring a ~~client~~Client when the ~~client~~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~~Client and Attendant are fully trained in the use of the equipment and the ~~client~~Client can direct and assist with the transfer.

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

i. Positioning when the ~~client~~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 the medications have been preselected by the ~~client~~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~~Client and opening the appropriately marked medication minder if the ~~client~~Client is unable to do so independently.

k. Cleaning and basic maintenance of durable medical equipment.

l. Protective oversight when the ~~client~~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~~Client, as indicated in the care plan, to medical appointments and errands, such as banking and household shopping. Accompanying the ~~client~~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: Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible ~~client~~Client in the community or in

the ~~client~~Client's home, which are necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out. Services may include:

a. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection and the ~~client~~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 directed by a Licensed Medical Professional.

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

   ii) In the presence of communicable disease;

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

   iv) Oral suctioning is required;

   v) There is decreased oral sensitivity or hypersensitivity;

   vi) ~~Client~~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:

   i) The ~~client~~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~~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~~Client is on a prescribed modified texture diet;

   iii) The ~~client~~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~~Client is unable to communicate verbally, non-verbally or through other means.

f. Exercise prescribed by a Licensed Medical Professional, including passive range of motion.

g. Transferring a ~~client~~Client when they are not able to perform transfers independently due to illness, injury or disability, or:

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

ii) The ~~client~~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~~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.

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

i) The ~~client~~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 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.

k. Respiratory care:

i) Postural drainage;

ii) Cupping;

iii) Adjusting oxygen flow within established parameters;

iv) Suctioning mouth and/or nose;

v) Nebulizers;

vi) Ventilator and tracheostomy care;

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

l. Bathing assistance is considered a health maintenance task when the ~~client~~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~~Client, as necessary according to the care plan, to medical appointments, and errands such as banking and household shopping. Accompanying the ~~client~~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~~Client is unable to assist or direct care;

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

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

p. Positioning includes moving the ~~client~~Client from the starting position to a new position while maintaining proper body alignment, support to a ~~client~~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~~Client is unable to assist or direct care, or

ii) The ~~client~~Client is unable to complete task independently

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

a. Homemaker services, as defined at Section 8.500.94.

b. Personal care services, as defined at Section 8.500.94.

c. Health maintenance activities as defined at Section 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~~Client is admitted to a nursing facility, hospital, a long-term care facility or incarcerated;

2. Following the death of ~~client~~Client;

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

Companionship is not a covered CDASS service.

8.510.5 ATTENDANT SUPPORT MANAGEMENT PLAN

8.510.5.A. The ~~client~~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 following initial training and retraining and shall be modified when there is a change in the ~~client~~Client's needs. The plan shall describe the ~~client~~Client's:

1. Needed Attendant support;

2. Plans for locating and hiring Attendants;

3. Plans for handling emergencies;

4. Assurances and plans regarding direction of CDASS Services, as described at 8.510.3 and 8.510.6, if applicable.

5. Plans for budget management within the ~~client~~Client's Allocation.

6. Designation of an AR, if applicable.

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

8.510.5.B. If the ASMP is disapproved by the Case Manager, the ~~client~~Client or AR has the right to review the disapproval. The ~~client~~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~~Client's most recently approved ASMP shall remain in effect while the review is in process.

8.510.6 CLIENT/AR RESPONSIBILITES

8.510.6.A. Client/AR responsibilities for CDASS Management:

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

2. Develop an ASMP at initial enrollment and at time of an Allocation change based on the ~~client~~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 for Attendants.

5. Recruit, hire and manage Attendants.

6. Complete employment reference checks on Attendants.

7. Train Attendants to meet the ~~client~~Client's needs. When necessary to meet the goals of the ASMP, the ~~client~~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~~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.

12. Follow all relevant laws and regulations applicable to the supervision of Attendants.

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

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

15. Authorize Attendant to perform services allowed through CDASS.

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

17. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement.

18. Authorize the FMS vendor to make any changes in the Attendant wages.

19. 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.

20. Completing and managing all paperwork and maintaining employment records.

21. Select an FMS vendor upon enrollment into CDASS.

8.510.6.B. Client/AR responsibilities for Verification:

1. Sign and return a responsibilities acknowledgement form for activities listed in 8.510.6 to the Case Manager.

8.510.6.C. Clients utilizing CDASS have the following rights:

1. Right to receive training on managing CDASS.

2. Right to receive program materials in accessible format.

3. Right to receive advance Notification of changes to CDASS.

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

5. Clients using CDASS have the right to transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.

6. A ~~client~~Client/AR may request a reassessment if the ~~client~~Client's level of service needs have changed.

7. A ~~client~~Client/AR may revise the ASMP at any time with Case Manager approval.

8.510.7 AUTHORIZED REPRESENTATIVES (AR)

8.510.7.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~~Client.

8.510.7.B. CDASS ~~client~~Clients who require an AR may not serve as an AR for another CDASS ~~client~~Client.

8.510.7.C. An AR shall not receive reimbursement for CDASS AR services and shall not be reimbursed as an Attendant for the ~~client~~Client they represent.

8.510.7.D. An AR must comply with all requirements contained in 8.510.6.

8.510.8 ATTENDANTS

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

8.510.8.B. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more ~~client~~Clients collectively.

8.510.8.C. An AR shall not be employed as an Attendant for the same ~~client~~Client for whom they are an AR.

8.510.8.D. Attendants must be able to perform the tasks on the ASMP they are being reimbursed for and the ~~client~~Client must have adequate Attendants to assure compliance with all tasks on the ASMP.

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

8.510.8.F. 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.G. 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.

8.510.8.H. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the ~~client~~Client/AR not to exceed the amount established by the Department. The FMS vendor shall make all payments from the ~~client~~Client's Allocation under the direction of the ~~client~~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~~Client. A list of barrier crimes is available through the Training and Operations Vendor and FMS vendors.

8.510.8.J. 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.

8.510.9 FINANCIAL MANAGEMENT SERVICES (FMS)

8.510.9.A. 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 workers' compensation insurance, unemployment benefits, withholding of all federal and state taxes, and compliance with federal and state laws regarding overtime pay and minimum wage.

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

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

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

6. Track and report utilization of ~~client~~Client allocations.

7. Comply with Department regulations and the FMS vendor contract with the Department.

8.510.9.B. In addition to the requirements set forth at 8.510.9.A, the FMS vendor operating under the F/EA model shall be responsible for obtaining designation as a Fiscal/Employer Agent in accordance with Section 3504 of the 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 Section ~~C.R.S. §~~ 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.510.10 SELECTION OF FMS VENDORS

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

8.510.10.B The ~~client~~Client/AR may select a new FMS vendor during the designated open enrollment periods. The ~~client~~Client/AR shall remain with the selected FMS vendor until the transition to the new FMS vendor is completed.

8.510.11 START OF SERVICES

8.510.11.A. The CDASS start date shall not occur until all of the requirements contained in 8.510.2, 8.510.5, 8.510.6 and 8.510.8 have been met.

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

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

8.510.11.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~~Client/AR with employee numbers and confirms Attendants' employment status.

8.510.11.E. If a ~~client~~Client is transitioning from a hospital, nursing facility, or HCBS agency services, the Case Manager shall coordinate with the discharge coordinator to ensure that the ~~client~~Client's discharge date and CDASS start date correspond.

8.510.12 SERVICE SUBSTITUTION

8.510.12.A. Once a start date has been established for CDASS, the Case Manager shall establish an end date and discontinue the ~~client~~Client from any other Medicaid-funded Attendant support including ~~Long Term~~Long-term Home Health, homemaker and personal care services effective as of the start date of CDASS.

8.510.12.B. Case Managers shall not authorize PARs with concurrent payments for CDASS and other waiver service delivery options for Personal Care services, Homemaker services, and Health Maintenance Activities for the same ~~client~~Client.

8.510.12.C. Clients may receive up to sixty days of Medicaid Acute Home Health services directly following acute episodes as defined by 8.523.11.K.1. CDASS service plans shall be modified to ensure no duplication of services.

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

8.510.13 FAILURE TO MEET CLIENT/AR RESPONSIBILITIES

8.510.13.A. If a ~~client~~Client/AR fails to meet their CDASS responsibilities, the ~~client~~Client may be terminated from CDASS. Prior to a ~~client~~Client being terminated from CDASS the following steps 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:

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

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

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

4. The ~~client~~Client/AR spends the monthly Allocation in a manner 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~~Client/AR exhibits Inappropriate Behavior as defined at 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor, or the FMS vendor.

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

8.510.14 IMMEDIATE INVOLUNTARY TERMINATION

8.510.14.A. ~~Client~~Clients may be involuntarily terminated immediately from CDASS for the following reasons:

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

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

3. The ~~client~~Client/AR exhibits Inappropriate Behavior as defined at 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 attempts to assist the ~~client~~Client/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

4. ~~Client~~Client/AR authorized the Attendant to perform services for a person other than the ~~client~~Client, authorized services not available in CDASS, or allowed services to be performed while the ~~client~~Client is in a hospital, nursing facility, a ~~long-term~~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~~Client/AR in managing appropriate services through retraining.

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 proven fraud, abuse, and/or theft in connection with the Colorado Medical Assistance program.

7. ~~Client~~Client/AR fails to complete retraining, appoint an AR, or remediate CDASS management per 8.510.13.A.

8.510.15 ENDING THE CDASS DELIVERY OPTION

8.510.15.A. If a ~~client~~Client chooses to use an alternate care option or is terminated involuntarily, the ~~client~~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~~Client or AR with the reasons for termination, information about the ~~client~~Client's rights to fair hearing, and appeal procedures. Once notice has been given for termination, the ~~client~~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~~Client. The Case Manager shall notify the FMS vendor of the date on which the ~~client~~Client is being terminated from CDASS.

8.510.15.C. Clients who are involuntarily terminated pursuant to 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 8.510.14.A.1. are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at 8.510.2.A.5. The ~~client~~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 8.510.14.A.3 are eligible for enrollment in CDASS with the appointment of an AR. The ~~client~~Client must meet all CDASS eligibility requirements with the AR completing CDASS training prior to enrollment in CDASS.

8.510.16 CASE MANAGEMENT FUNCTIONS

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

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

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

1. Calculate the number of personal care, homemaker, and health maintenance activities hours needed on a monthly basis using the Department's prescribed method. The needs

determined for the Allocation should reflect the needs in the Department-approved assessment tool and the service plan. The Case Manager shall use the Department's established rate for personal care, homemaker, and health maintenance activities to determine the ~~client~~Client's Allocation.

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

8.510.16.D. Prior to training or when an Allocation changes, the Case Manager shall provide written Notification of the Allocation to the ~~client~~Client and the AR, if applicable.

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

1. If the review indicates that a change in Attendant support is justified, the following actions will be taken:

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

   b. The Case Manager shall complete a PAR revision indicating the increase in CDASS Allocation using the 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~~Client/AR shall amend the ASMP and submit it to the Case Manager.

2. 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.

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

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

1. Any deterioration in the ~~client~~Client's functioning or change in availability of natural supports, meaning assistance provided to the ~~client~~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 for CDASS services.

8.510.16.G. In reducing a ~~client~~Client's 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~~Client's previously reported condition or need for service.

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

8.510.16.H. Case Managers shall cease payments for all existing Medicaid-funded personal care, homemaker, health maintenance activities and/or Long-Term Home Health as defined under the Home Health Program at Section §8.520 et seq. as of the ~~client~~Client's CDASS start date.

8.510.16.I. For effective coordination, monitoring and evaluation of ~~client~~Clients receiving CDASS, the Case Manager shall:

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

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

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

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

5. Utilize Department overspending protocol when needed to assist CDASS ~~client~~Clients/AR.

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

8.510.16.J. Reassessment: The Case Manager will follow in-person and phone contact requirements based on the ~~client~~Client's waiver program. Contacts shall include a review of care needs, the ASMP, and documentation from the physician, physician assistant, or advance practice nurse stating the ~~client~~Client'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.

8.510.17 ATTENDANT REIMBURSEMENT

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

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

8.510.17.C. Once the ~~client~~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~~Client is no longer eligible for CDASS or when the ~~client~~Client's Allocation has been depleted are the responsibility of the ~~client~~Client/AR.

8.510.17.D. Allocations that exceed the cost of providing services in a facility cannot be authorized by the Case Manager without Department approval.

8.510.18 REIMBURSEMENT TO FAMILY MEMBERS

8.510.18.A. Family Members/legal guardians may be employed by the ~~client~~Client/AR to provide CDASS, subject to the conditions below.

8.510.18.B. The family member or legal guardian shall be employed by the ~~client~~Client/AR and be supervised by the ~~client~~Client/AR.

8.510.18.C. The Family Member and/or legal guardian being reimbursed as a personal care, homemaker, and/or health maintenance activities Attendant shall be reimbursed at an hourly rate with the following restrictions:

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

3. A member of the ~~client~~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 would ordinarily perform in the 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~~Client and avoid institutionalization. Extraordinary care shall be documented on the service plan.

8.510.18.D. A ~~client~~Client/AR who chooses a Family Member as a care provider, shall document the choice on the ASMP.

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~~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) (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 (2018). 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~~Home and Community-based Services for Persons with Brain Injury Act, Sections 25.5-6-701 et seq., C.R.S.

8.515.2 HCBS-BI WAIVER SERVICES

8.515.2.A SERVICES PROVIDED

1. Adult Day Services
2. Behavioral Programming and Education
3. Consumer Directed Attendant Support Services (CDASS)
4. Counseling Services
5. Day Treatment
6. Electronic Monitoring Services
7. Home Delivered Meals
8. Home Modification
9. Independent Living Skills Training (ILST)
10. Non-Medical Transportation Services
11. Peer Mentorship
12. Personal Care
13. Respite Care
14. Specialized Medical Equipment and Supplies
15. Substance Abuse Counseling
16. Supported Living
17. Transition Setup
18. Transitional Living Program

8.515.2.B DEFINITIONS OF SERVICES

1. Adult Day Services means services as defined at Section 8.491.
2. Behavioral Programming and Education means services as defined at Section 8.516.40.
3. Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.
4. Counseling Services means services as defined at Section 8.516.50.
5. Day Treatment means services as defined at Section 8.515.80.

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

7. Home Delivered Meals means services as defined at Section 8.553.

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

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

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

11. Peer Mentorship means services as defined at Section 8.553.

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

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

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

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

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

17. Transition Setup means services defined at Section 8.553.

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

8.515.3 GENERAL DEFINITIONS

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

1. Nonpsychotic mental disorders due to brain damage; or

2. Anoxic brain damage; or

3. Compression of the brain; or

4. Toxic encephalopathy; or

5. Subarachnoid and/or intracerebral hemorrhage; or

6. Occlusion and stenosis of precerebral arteries; or

7. Acute, but ill-defined cerebrovascular disease; or

8. Other and ill-defined cerebrovascular disease; or

9. Late effects of cerebrovascular~~cerebrovasular~~ disease; or

10. Fracture of the skull or face; or

11. Concussion resulting in an ongoing need for assistance with activities of daily living; or

12. Cerebral laceration and contusion; or

13. Subarachnoid, subdural, and extradural hemorrhage, following injury; or

14. Other unspecified intracranial hemorrhage following injury; or

15. Intracranial injury; or

16. Late effects of musculoskeletal and connective tissue injuries; or

17. Late effects of injuries to the nervous system; or

18. Unspecified injuries to the head resulting in ongoing need for assistance with activities of daily living.

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

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

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

8.515.4 SCOPE AND PURPOSE

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

8.515.5 ELIGIBLE PERSONS

HCBS-BI program enrollment and services shall be offered only to individuals determined by the Department or its agent to have met all eligibility requirements in this Section 8.515.5.

8.515.5.A LEVEL OF CARE

Eligible individuals shall be determined by the Department or its agent to require one of the following levels of care:

1. Hospital Level of Care as evidenced by:

   a. The individual shall have been:

      i. Referred to the Case Management Agency while receiving inpatient care in an acute care or rehabilitation hospital for the treatment of the individual's brain injury; or

      ii. Determined by the Department or its agent to have a significant functional impairment as evidenced by a comprehensive functional assessment using the Uniform Long-t ~~T~~erm Care 100.2 (ULTC 100.2)

assessment tool that results in at least the minimum scores required by Section 8.401.1.15; and

c. The individual shall require goal--oriented therapy with medical management by a physician; and

d. The individual cannot be therapeutically managed in a community-based setting without significant supervision and structure, specialized therapy, and support services.

2. Nursing Facility Level of Care as evidenced by ~~all of~~all the following:

a. The individual shall have been determined by the Department or its agent to have a significant functional impairment as evidenced by a comprehensive functional assessment using the Uniform Long-t ~~T~~erm Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15;

b. The individual shall require ~~long term~~long-term support services at a level comparable to those services typically provided in a nursing facility.

8.515.5.B TARGET GROUP

Eligible individuals shall be determined by the Department or its agent to meet all ~~of~~ the following target group criteria:

1. The individual shall have a diagnosis of Brain Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) ~~of~~ and the ULTC 100.2 assessment tool.

2. Age Limit

a. Individuals enrolled in the Brain Injury waiver shall be aged 16 years and older and shall have sustained the brain injury prior to the age of 65.

8.515.5.C FINANCIAL ELIGIBILITY

Individuals must meet the financial requirements for ~~long term~~long-term care medical assistance eligibility specified at Section 8.100.7.

8.515.5.D NEED FOR HCBS-BI SERVICES

1. Only ~~client~~Clients that currently receive HCBS-BI services, or that have agreed to accept HCBS-BI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-BI program.

a. Case management is provided as an administrative function, not an HCBS-BI service, and shall not be used to satisfy this requirement.

b. The desire or need for any Medicaid services other than HCBS-BI services, as listed at Section 8.515.1, shall not satisfy this eligibility requirement.

2. Clients that have not received an HCBS-BI service for a period greater than 30 consecutive days shall be discontinued from the program.

8.515.5.E EXCLUSIONS FROM ELIGIBILITY

1. Individuals who are residents of nursing facilities, hospitals, or other institutional settings are not eligible to receive HCBS-BI services.

2. HCBS-BI ~~client~~Clients that enter a nursing facility or hospital may not receive HCBS-BI services while admitted to the nursing facility or hospital.

   a. HCBS-BI ~~client~~Clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-BI program.

   b. HCBS-BI ~~client~~Clients entering a nursing facility for Respite Care as an HCBS-BI service shall not be discontinued from the HCBS-BI program.

8.515.5.F COST CONTAINMENT AND SERVICE ADEQUACY OF SERVICES

1. The ~~client~~Client shall not be eligible for the HCBS-BI program if the case manager determines any of the following during the initial assessment and service planning process:

   a. The ~~client~~Client's needs cannot be met within the Individual Cost Containment Amount.

   b. The ~~client~~Client's needs are more extensive than HCBS-BI program services are able to support and/or that the ~~client~~Client's health and safety cannot be assured in a community setting.

2. The ~~client~~Client shall not be eligible for the HCBS-BI program at reassessment if the case manager determines the ~~client~~Client's needs are more extensive than HCBS-BI program services are able to support and/or that the ~~client~~Client's health and safety cannot be assured in a community setting.

3. If the case manager determines that the ~~client~~Client's needs are more extensive than the HCBS-BI services are able to support and/or that the ~~client~~Client's health and safety cannot be assured in a community setting, the case manager must document:

   a. The results of an Adult Protective Services assessment;

   b. A statement from the ~~client~~Client's physician attesting to the ~~client~~Client's mental competency status; and

   c. Any other documentation necessary to support the determination

4. The ~~client~~Client may be eligible for the HCBS-BI program at reassessment if the case manager determines that HCBS-BI program services are able to support the ~~client~~Client's needs and the ~~client~~Client's health and safety can be assured in a community setting.

   a. If the case manager expects that the services required to support the ~~client~~Client's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the ~~client~~Client's request for services is appropriate and justifiable based on the ~~client~~Client's condition.

      i. The ~~client~~Client may request of the case manager that existing services remain intact during this review process.

ii. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the ~~client~~Client with:

1) The ~~client~~Client's appeal rights pursuant to Section 8.057; and

2) Alternative options to meet the ~~client~~Client's needs that may include, but are not limited to, nursing facility placement.

8.515.6 START DATE FOR SERVICES

8.515.6.A. The start date of eligibility for HCBS-BI services shall not precede the date that all of the requirements in Section 8.515.5, have been met. The first date for which HCBS-BI services may be reimbursed shall be the later the following:

1. The date at which financial eligibility is effective.

2. The date at which the Department or its agent has determined that the ~~client~~Client has met all eligibility requirements at Section 8.515.5.

3. The date at which the ~~client~~Client agrees to accept services and signs all necessary intake and service planning forms.

4. The date of discharge from an institutional setting.

8.515.7 PRIOR AUTHORIZATION OF SERVICES

8.515.7.A. All HCBS-BI services must be prior authorized by the Department or its agent.

8.515.7.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

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

1. Consistent with the ~~client~~Client's documented medical condition and functional capacity;

2. Reasonable in amount, scope, frequency, and duration;

3. Not duplicative of the other services or supports included in the ~~client~~Client's Service Plan;

4. Not for services for which the ~~client~~Client is receiving funds to purchase; and

5. Do not total more than 24 hours per day of care.

8.515.7.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

8.515.7.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-BI services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR.

1. Payment for HCBS-BI services is also conditional upon:

a. The ~~client~~Client's eligibility for HCBS-BI services;

b. The provider's certification status; and

c. The submission of claims in accordance with proper billing procedures.

8.515.7.F. The prior authorization of services does not constitute an entitlement to those services. All services provided and reimbursed must be delivered in accordance with regulation and be necessary to meet the ~~client~~Client's needs.

8.515.7.G. Services requested on the PAR shall be supported by information on the Service Plan and the ULTC-100.2 assessment.

8.515.7.H. The PAR start date shall not precede the start date of HCBS-BI eligibility in accordance with Section 8.515.6.

8.515.7.I. The PAR end date shall not exceed the end date of the HCBS-BI eligibility certification period.

8.515.8 WAITING LIST

8.515.7.A. Persons determined eligible for HCBS-BI services that cannot be served within the capacity limits of the HCBS-BI waiver shall be eligible for placement on a waiting list.

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

2. The date used to establish the person's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.515.5 were determined to have been met and the HCBS-BI Program Administrator was notified.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the date of their waiting list placement.

8.515.9 CASE MANAGEMENT FUNCTIONS

The requirements at Section 8.393 shall apply to the Case Management Agencies performing the case management functions of the HCBS-BI program.

8.515.10 PROVIDER AGENCIES

HCBS-BI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

8.515.50 ASSISTIVE AND SPECIAL MEDICAL EQUIPMENT

A. DEFINITIONS

Specialized medical equipment and supplies includes devices controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Assistive Devices include equipment which meets one of the following criteria:

1. Is useful in augmenting an individual's ability to function at a higher level of independence and lessen the number of direct human service hours required to maintain independence;

2. Is necessary to ensure the health, welfare and safety of the individual;

3. Enables the individual to secure help in the event of an emergency;

4. Is used to provide reminders to the individual of medical appointments, treatments, or medication schedules; or

5. Is required because of the individual's illness impairment or disability, as documented on the screening assessment form and the plan of can.

B. INCLUSIONS

1. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

2. Items which are not of direct medical or remedial benefit to the recipient are excluded.

3. Assistive devices to augment cognitive processes, “cognitive-orthotics” or memory prostheses are included in this service area. Examples of cognitive orthotic devices include informational data bases, spell checkers, text outlining programs, timing devices, security systems, car finders, sounding devices, cuing watches, telememo watches, paging systems, electronic monitoring, tape recorders, electronic checkbooks, electronic medication monitors, and memory telephone.

C. CERTIFICATION REQUIREMENTS

Certification standards refer to both the supplier of equipment as well as the actual product or equipment itself.

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

2. All equipment materials or appliances used as pan of monitoring systems shall carry a UL (Underwriter's Laboratory) number or an equivalent standard.

3. All telecommunications equipment shall be FCC registered.

4. All equipment materials, or appliances shall be installed by properly trained individuals, and the installer shall train the ~~client~~Client in the use of the device.

5. All equipment, materials or appliances shall be tested fir proper functioning at the time of installation and at periodic intervals thereafter by a properly trained individual.

6. Any malfunction shall be promptly repaired by a properly trained technician supplied at the provider agency's expense. Equipment shall be replaced when necessary, including buttons and batteries.

7. Assistive equipment providers shall send written information to each ~~client~~Client’s case manager about the item, how it works, and how it should be maintained.

D. REIMBURSEMENT METHOD FOR ASSISTTVE DEVICES

Reimbursement for assistive devices will be on a per unit basis. If assistive devices are to be used primarily in a vocational application, devices should be funded through the Division of Vocational Rehabilitation with secondary funding from Medicaid.

8.515.70 ADULT DAY SERVICES

A. DEFINITIONS

1. Adult Day Services means both health and social services furnished on a regularly scheduled basis in an adult day services center two or more hours per day, one or more days per week to ensure the optimal functioning of the ~~client~~Client Services are directed towards recreation and socialization as well as maintaining a safe and supportive environment.

2. Adult Day Services Center means a non-institutional entity that conforms to requirements for maintenance

3. Maintenance Model means services in health monitoring and individual and group therapeutic and psychological activities which serve as an alternative to long-term nursing home care.

4. Adult day services include:

   a. Daily monitoring to assure that ~~client~~Clients are maintaining personal hygiene and participating in age appropriate social activities as prescribed; and assisting with activities prescribed; and assisting with activities of daily living (e.g., eating, dressing).

   b. Emergency services including whiten procedures to meet medical crises.

   c. Assistance in the development of self-care capabilities personal hygiene, and social support services.

   d. Provision of nutritional needs appropriate to the hours in which the ~~client~~Client is served.

   e. Nursing services as necessary to supervise medication regimen of trained medication aides and carry out any of the services listed as SKILLED CARE in SECTION 8.489.30.

   f. Social and recreational services as prescribed to meet the ~~client~~Client's needs.

   g. Any additional services if such services are included in the budget submitted to the Department in accordance with the section on REIMBURSEMENT METHOD FOR ADULT DAY CARE below~~,~~ and determined by the Department to be necessary for adult day care.

B. CERTIFICATION STANDARDS

All adult day service centers shall conform to all of the following Departmental standards

1. All providers must conform to all established departmental standards in the general certification standards section.

2. All providers of adult service care shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The agency shall provide a clean environment, free of obstacle; that could pose a hazard to ~~client~~Client health and safety.

4. Agencies shall provide lockers or a safe place for ~~client~~Client's' personal items.

5. Adult day service centers shall provide recreational areas and activities appropriate to the number and needs of the recipients.

6. Drinking facilities shall be located within easy access to residents.

7. Adult day service centers shall provide eating and resting areas consistent with the number and needs of the ~~client~~Clients being served.

8. Adult day service centers shall provide easily accessible toilet facilities, hand washing facilities and paper towel dispensers.

9. The center shall be accessible to ~~client~~Clients with supportive devices for ambulation or who an in wheelchairs.

C. RECORDS AND INFORMATION

Adult day service providers shall keep such records and information necessary to document the services provided to ~~client~~Clients receiving adult day services. Medical Information Records shall include but not be limited to:

1. Medications the ~~client~~Client is taking and whether they are being self-administered.

2. Special dietary needs, if any.

3. Restrictions on activities identified by physician in the case plan.

D. STAFFING

All adult day service centers shall have staff who have been trained in current cardiopulmonary resuscitation, seizure prophylaxis and control and brain injury. Adequate staff shall be on the premises at all times to ensure:

1. Supervision of ~~client~~Clients at all times during the operating hours of the program.

2. Immediate response to emergency situations to assure the welfare of ~~client~~Clients.

3. Provision of prescribed recreational and social activities.

4. Provision of administrative, recreational, social and supportive functions of the adult day services center.

E. POLICIES

The center shall have a written policy relevant to the operation of the adult day services center. Such policy shall include but not be limited to statements describing:

1. Admission criteria that qualify ~~client~~Clients to be appropriately served in the center.

2. Interview procedures conducted for qualified ~~client~~Clients and/or family members prior to admission to the center.

3. The meals and nourishments that will be provided, including special diets.

4. The hours that the ~~client~~Clients will be served in the center and days of the week services will be available.

5. The personal items participants may bring with them to the center.

6. A written signed contract to be drawn up between the ~~client~~Client or responsible party and the center outlining rules and responsibilities of the center and of the ~~client~~Client Each parry of the contract will have a copy.

7. A statement of the center's policy for providing drop in care or day respite.

F. REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

1. Reimbursement for adult day services shall be based upon a single a single all-inclusive payment rate per unit of service for each participating provider.

2. Each provider will be paid on a per diem statewide uniform rate. The rate of payment shall be subject to available appropriations and may be the lower of the billed amount or the Medicaid allowable rate which is determined by multiplying the number of units times a rate established by the Department

8.515.80 DAY TREATMENT

A. DEFINITION

Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the recipient lives.

B. PROGRAM COMPONENTS, POLICIES AND PROCEDURES

1. Treatment plans are coordinated by a comprehensive interdisciplinary team which includes the recipient and his/her family and provides for consolidation of services in one location.

2. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, case management, and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan.

3. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statue.

4. The provider shall network with all allied medical professionals and other community-based resource providers.

5. Services include social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management).

6. Crisis situations with family, ~~client~~Client or staff shall be addressed through counseling and referral to appropriate professionals.

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

8. There shall be regular contact and meetings with the ~~client~~Clients and their families to discuss treatment plan progress and revision.

9. Discharge planning will include the development of a plan which considers safety, environmental modification to support individual function, education of the family and caregiver, recommendations for the future, and referral to additional community resources.

10. Each entity must have a process, verified in writing, by which a ~~client~~Client is made aware of the process for filing a grievance.

11. Complaints by the ~~client~~Client or family are handled within a 24-hour period from the time of complaint by at least telephone contact.

12. Transportation between therapeutic tasks in the community shall be included in the per diem cost of day treatment.

13. There shall be an inform and consent mechanism by which the ~~client~~Client, family medical proxy or substitute decision maker is made aware of the inherent risks associated with community-based rehabilitation programs. Examples of such risks might include a greater likelihood of falling accidents, traffic hazards and access to drugs or alcohol.

C. HUMAN RIGHTS

Every person receiving HCBS-BI services has the following rights:

1. Every person shall mutually develop and sign their treatment plan.

2. Every person has the right to enjoy freedom of thought, conscience, and religion.

3. Every person has the right to live in a clean, safe environment.

4. Every person has the right to have his or her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his or her life.

5. Every person has the right to be free from physical abuse and inhumane treatment.

6. Every person has the right to be protected from all forms of sexual exploitation.

7. Every person has the right to access necessary medical care which is adequate and appropriate to their condition.

8. Every person has the right to communicate with significant others.

9. Every person has the right to reasonable enjoyment of privacy in personal conversations.

10. Every person has the right to have access to telephones, both to make and receive calls in privacy.

11. Every person has the right to have frequent and convenient opportunities to meet with visitors.

12. Every person has the right to the same consideration and treatment as anyone else regardless of racefface, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status, or disability.

13. Every person who acts as his own legal guardian has the right to accept treatment of his/her own free will.

14. Nothing in this pan shall be construed to prohibit necessary assistance as appropriate, to those individuals who may require such assistance to exercise their rights.

15. Every person has the right to be free of physical restraint unless physical intervention is necessary to prevent such body movement that is likely to result in imminent injury to self or others, and only if alternative techniques have failed. Mechanical restraints are not allowed.

D. DOCUMENTATION

1. Intake information shall include a complete neuropsychological assessment and all pertinent medical documentation from inpatient and outpatient therapy and social history to identify key treatment components and communicate the functional implications of treatment goals.

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

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

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

5. Progress notes will be kept to support document specific treatment modalities rendered by date and signed by the therapist providing the service.

E. CERTIFICATION STANDARDS

1. Directors of day treatment programs shall have professional licensure in a health-related program in combination with at least 2 years of experience in head trauma rehabilitation programming.

2. All providers shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The agency shall provide a clean environment, free of obstacles that could pose a hazard to clientClient health and safety.

4. Agencies shall provide lockers or a safe place for clientClients' personal items.

5. Day treatment centers shall provide age appropriate activities and provide eating and resting areas consistent with the number and needs of the clientClients being served.

6. The center shall be accessible according to guidelines established by the Americans with Disabilities Act.

7. Personnel shall have training appropriate to the medical needs of the ~~client~~Clients served including seizure management training, CPR certification, non-violent crisis intervention, and personal care standards according to SECTION-PERSONAL CARE 8.489.40.

F. REIMBURSEMENT

Day treatment services will be paid on a per diem basis at a rate to be determined by the Department In order for a provider to be paid for a day of treatment, a ~~client~~Client must have attended and received therapeutic intervention which is substantiated by case file notes signed by the rendering therapist

8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.A DEFINITIONS

1. Activities of Daily Living (ADLs) mean basic self-care activities, including mobility, bathing, toileting, dressing, eating, transferring, support for memory and cognition, and behavioral supervision.

2. Assistance means the use of manual methods to guide or assist with the initiation or completion of voluntary movement or functioning of an individual's body through the use of physical contact by others, except for the purpose of providing physical restraint.

3. Assistive Technology Devices means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

4. Authorized Representative means an individual designated by the ~~client~~Client or the legal guardian, if appropriate, who has the judgment and ability to assist the ~~client~~Client in acquiring and utilizing supports and services.

5. Behavioral Management and Education means services as defined in § 8.516.40.A, and Inclusions as defined at § 8.516.40.B, provided as an individually developed intervention designed to decrease/control the ~~client~~Client's severe maladaptive behaviors which, if not modified, will interfere with the ~~client~~Client's ability to remain integrated in the community.

6. Case Management Agency (CMA) means an agency within a designated service area where an applicant or ~~client~~Client can obtain Case Management services. CMAs include Single Entry Points (SEPs), Community Centered Boards (CCBs), and private case management agencies.

7. Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual ~~client~~Client's functional eligibility for the Home and Community-~~-b~~Based Services – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and person-centered Service Plan for the ~~client~~Client, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such ~~client~~Client's needs.

8. Critical Incident means an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a ~~client~~Client that could have, or has had, a negative impact on the mental and/or physical well-being of a ~~client~~Client in the short or ~~long term~~long-term. A critical incident includes accidents, a suspicion of, or actual abuse, neglect, or exploitation, and criminal activity.

9. Department means the Department of Health Care Policy and Financing.

10. Health Maintenance Activities means those routine and repetitive health-related tasks which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These activities include, but are not limited to, catheter irrigation, administration of medication, enemas, suppositories, and wound care.

11. Independent Living Skills Training means services designed and directed toward the development and maintenance of the ~~client~~Client's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

12. Instrumental Activities of Daily Living (IADLs) means activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework and communication.

13. Interdisciplinary Team means a group of people responsible for the implementation of a ~~client~~Client's individualized care plan, which includes the ~~client~~Client receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by the ~~client~~Client's needs and preferences, who are assembled in a cooperative manner to develop or review the person-centered care plan.

14. Personal Care Services includes providing assistance with eating, bathing, dressing, personal hygiene or other activities of daily living. When specified in the service plan, Personal Care Services may also include housekeeping chores such as bed making, dusting, and vacuuming. Housekeeping assistance must be incidental to the care furnished or essential to the health and welfare of the individual rather than for the benefit of the individual's family.

15. Person-Centered Care Plan is a service plan created by a process that is driven by the individual and can also include people chosen by the individual pursuant to 42 C.F.R. § 441.540. It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents ~~client~~Client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the ~~client~~Client needs to function safely in the community.

16. Protective Oversight is defined as monitoring and guidance of a ~~client~~Client to assure his/her health, safety, and well-being. Protective oversight includes, but is not limited to: monitoring the ~~client~~Client while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the ~~client~~Client to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the ~~client~~Client's choice and ability to travel and engage independently in the wider community~~,~~ and providing guidance on safe behavior while outside the Supportive Living Program.

17. Room and Board is defined as a comprehensive set of services that include lodging, routine or basic supplies for comfortable living, and nutritional and healthy meals and food for the ~~client~~Client, all of which are provided by the Supportive Living Program provider, and are not included in the per diem.

18. Supportive Living Program (SLP) certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to the Department after the SLP provider has met all licensing requirements found in 6 C.C.R. 1011-1; Chapter 2, and either Chapter 7 or 26, in addition to all requirements in § 8.515.85.

8.515.85.B CLIENT ELIGIBILITY

1. SLP services are available to individuals who meet all of the following requirements:

   a. Clients are determined functionally eligible for HCBS-BI waiver by a certified case management agency;

   b. Clients are enrolled in the HCBS-BI waiver; and

   c. Clients require the specialized services provided under the SLP as determined by assessed need.

8.515.85.C SUPPORTIVE LIVING PROGRAM INCLUSIONS

1. SLP services consist of structured services designed to provide:

   a. Assessment;

   b. Protective Oversight and supervision;

   c. Behavioral Management and Education;

   d. Independent Living Skills Training in a group or individualized setting to support:

      i. Interpersonal and social skill development;

      ii. Improved household management skills; and

      iii. Other skills necessary to support maximum independence, such as financial management, household maintenance, recreational activities and outings, and other skills related to fostering independence;

   e. Community Participation;

   f. Transportation between therapeutic activities in the community;

   g. Activities of Daily Living (ADLs);

   h. Personal Care and Homemaker services; and

   i. Health Maintenance Activities.

2. Person-Centered Care Planning

   SLP providers must comply with the Person-Centered Care Planning process. Providers must work with CMAs to ensure coordination of a ~~client~~Client's Person-Centered Care Plan. Additionally, SLP providers must provide the following actionable plans for all HCBS-BI waiver ~~client~~Clients, updated every six (6) months:

   a. Transition Planning; and

   b. Goal Planning.

   These elements of a Person-Centered Care Plan are intended to ensure the ~~client~~Client actively engages in his or her care and activities, as is able to transition to any other type of setting or service at any given time.

3. Exclusions

The following are not included as components of the SLP:

a. Room and board; and

b. Additional services which are available as a State Plan benefit or other HCBS-BI waiver service. Examples include, but are not limited ~~to:~~to physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, ~~long term~~long-term home health, and private duty nursing.

8.515.85.D PROVIDER LICENSING AND CERTIFICATION REQUIREMENTS

1. To be certified as an SLP provider, the entity seeking certification must be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. 7, except as provided below.

a. Subject to Department approval, providers that have been in continuous operation at the same address prior to 1987 may continue to furnish SLP services under a Home Care Agency (HCA) license pursuant to 6 CCR 1011-1, Ch. 26 instead of the ALR license.

i. Providers furnishing SLP services under a Department-approved exception are required to comply with this § 8.515.85, regardless of licensure type.

ii. Providers furnishing SLP services under a Department-approved exception are required to comply with the medication administration requirements pursuant to both the HCA licensure requirements found at 6 CCR 1011-1, Chapters 7 and~~.~~ 26, and ~~C.R.S.~~ Section~~§~~ 25-1.5-301 through 304, ~~C.R.S.6 CCR 1011-1, Ch. 24, and 6 CCR 1011-1, Ch. 7, § 14, (2018).~~ 6 CCR 1011-1, Ch. 7, ~~§~~ Section 14, (2018) is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to ~~C.R.S. §~~Section 24-4-103 (12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. In addition to the requirements of § 8.515.85.D.1, SLP providers must also receive SLP Certification from CDPHE. CDPHE issues or renews a Certification when the provider is in full compliance with the requirements set out in these regulations. Certification is valid for three years from the date of issuance unless CDPHE revokes, suspends, or takes other disciplinary action against the licensee,~~,~~ or the certification is voluntarily relinquished by the provider.

3. No Certification shall be issued or renewed by CDPHE if the owner, applicant, or administrator of the SLP has been convicted of a felony or of a misdemeanor, which felony or misdemeanor involves moral turpitude or involves conduct that the Department determines could pose a risk to the health, safety, or welfare of residents of the assisted living residence.

8.515.85.E PROVIDER RESPONSIBILITIES

SLP providers must follow all person-centered planning initiatives undertaken by the State to ensure ~~client~~Client choice.

8.515.85.F HCBS PROGRAM CRITERIA

1. In accordance with 42 C.F.R. § 441.530, Home and Community-~~-~~bB~~a~~ased settings must:

   a. Be integrated in and support full access to the greater community;

   b. Be selected by the ~~client~~Client from among setting options;

   c. Ensure ~~client~~Client rights of privacy, dignity, and respect, and freedom from coercion and restraint;

   d. Optimize individual initiative, autonomy, and independence in making life choices;

   e. Facilitate ~~client~~Client choice regarding services and supports, and who provides them;

   f. Be a specific, physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity;

   g. Ensure privacy in the ~~client~~Client's unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;

   h. Ensure that ~~client~~Clients have the freedom and support to control their own schedules and activities, and have access to food at any time;

   i. Ensure each ~~client~~Client has the right to receive and send packages. No ~~client~~Client's outgoing packages shall be opened, delayed, held, or censored by any person;

   j. Ensure each ~~client~~Client has the right to receive and send sealed, unopened correspondence. No ~~client~~Client's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person;

   i. Enable ~~client~~Clients to have visitors of their choosing at any time; and

   j. Be physically accessible.

2. Exceptions

   The Department may grant exceptions to HCBS Program Criteria listed in § 8.515.85.F.1, a through h, when reasonable, as follows:

   a. Requirements of program criteria may be modified if supported by a specific assessed need and justified in the person-centered care plan. The following requirements must be documented in the person-centered care plan:

i. Identify a specific and individualized assessed need.

ii. Document the positive interventions and supports used prior to any modifications to the person-centered care plan.

iii. Document less intrusive methods of meeting the need that have been tried but did not work.

iv. Include a clear description of the modification that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

viii. Include an assurance that interventions and supports will cause no harm to the individual.

b. HCBS Program Criteria under 8.515.85.F.1.b and e:

i. When a ~~client~~Client chooses to receive HCBS in a provider-owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the ~~client~~Client cannot choose an alternative provider to deliver services that are included in the bundled rate.

ii. For any services that are not included in the bundled rate, the ~~client~~Client may choose any qualified provider, including the provider who controls or owns the setting, if the provider offers the service separate from the bundle.

c. HCBS Program Criteria under 8.515.85.F.1.c:

When a ~~client~~Client needs assistance with challenging behavior, including a ~~client~~Client whose behavior is dangerous to himself, herself, or others, or when the ~~client~~Client engages in behavior that results in significant property destruction, the SLP must create detailed service and support plans that describe how to appropriately address these behaviors.

d. HCBS Program Criteria under 8.515.85.F.1.g:

Requirements for a lockable entrance door may be modified if supported by a specific assessed need and justified in the person-centered service plan.

8.515.85.G STAFFING

1. The SLP provider shall ensure sufficient staffing levels to meet the needs of ~~client~~Clients.

2. The operator, staff, and volunteers who provide direct ~~client~~Client care or protective oversight must be trained in precautions and emergency procedures, including first aid, to ensure the safety of the clientele.

3. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections ~~§§~~ 6, 7, and 8, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to ~~C.R.S. §~~Section 24-4-103(12.5) C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

4. Within one month of the date of hire, the SLP provider shall provide adequate training for staff on each of the following topics:

   a. Crisis prevention;

   b. Identifying and dealing with difficult situations;

   c. Cultural competency;

   d. Infection control; and

   e. Grievance and complaint procedures.

5. Prior to providing direct care, the SLP provider shall provide to the operator, staff, and volunteers an orientation to the location in which the program operates, and adequate training on person-centered care planning.

6. All staff training shall be documented. Copies of person-centered care plan training and related documentation must be submitted to the Department upon request. Prior to any subsequent change in the training curriculum, the provider must submit copies to the Department for review and approval.

7. In addition to the requirements of 6 CCR 1011-1 Ch. 7 , the Department requires that the program director shall have an advanced degree in a health or human service related profession plus two years of experience providing direct services to persons with a brain injury. A bachelor's or nursing degree with three years of similar experience, or a combination of education and experience shall be an acceptable substitute.

8. The provider shall employ or contract for behavioral services and skill training services according to ~~client~~Client needs.

9. The SLP shall ensure that provision of services is not dependent upon the use of ~~client~~Clients to perform staff functions. Volunteers may be utilized in the home~~,~~ but shall not be included in the provider's staffing plan in lieu of employees.

10. The SLP provider shall maintain written personnel policies~~,~~ and shall provide a copy of these policies to each staff member upon employment. The administrator or designee shall explain such policies during the initial staff orientation period.

11. The SLP provider shall conduct a criminal background check through the Colorado Bureau of Investigation for all staff, prospective staff, and volunteers. The provider shall not employ any person convicted of an offense that could pose a risk to the health, safety, and welfare of ~~client~~Clients. The provider shall bear all costs related to obtaining a criminal background check.

8.515.85.H CLIENT RIGHTS AND PROPERTY

1. Clients shall have all rights stated in § 8.515.85.F.1.

2. Any provider that chooses to handle ~~client~~Client funds and property must maintain policies and practices for management of ~~client~~Client funds and property that are consistent with those at 6 CCR 1011-1, Ch. 7, Section~~§~~ 11.10.

3. Upon ~~client~~Client request, a ~~client~~Client shall be entitled to receive, and the provider shall promptly deliver, available money or funds held in trust.

8.515.85.I FIRE SAFETY AND EMERGENCY PROCEDURES

1. Applicants for initial provider Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by DFPC.

   a. The Department may grant an exception to this provision for a provider qualified under § 8.515.85.D.1.c, if the provider holds a current certificate of compliance from the local fire authority.

3. Providers shall develop written emergency plans and procedures for fire, serious illness, severe weather, disruption of essential utility services, and missing persons for each ~~client~~Client. Emergency and evacuation procedures shall be consistent with any relevant local and state fire and life safety codes and the provisions set forth in 6 CCR 1011-1 Ch. 7, § 10.

4. Within three (3) days of scheduled work or commencement of volunteer service, the program shall provide adequate training for staff in emergency and fire escape plan procedures.

5. SLP providers must train all staff and ~~client~~Clients on emergency plans and procedures at intervals throughout the year. Providers shall conduct fire drills at least once every six (6) months, during the evening and overnight hours while ~~client~~Clients are sleeping. All such practices and training shall be documented and reviewed every six (6) months. Such documentation shall include any difficulties encountered and any needed adaptations to the plan. Such adaptations shall be implemented immediately upon identification.

8.515.85.J ENVIRONMENTAL AND MAINTENANCE REQUIREMENTS

1. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, ~~§§~~ Sections 15,16, 17, and 19, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to ~~C.R.S. §~~Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. The interior and exterior environment of the SLP residence shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections ~~§§~~ 20, 21, 22, 23, and 24, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to ~~C.R.S. §~~ Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at

cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

3. ~~Client~~Clients shall be allowed free use of all common living areas within the residence, with due regard for privacy, personal possessions, and safety of ~~client~~Clients.

4. SLP providers shall develop and implement procedures for the following:

   a. Handling of soiled linen and clothing;

   b. Storing personal care items;

   c. General cleaning to minimize the spread of pathogenic organisms; and

   d. Keeping the home free from offensive odors and accumulations of dirt and garbage.

5. The SLP provider shall ensure that each ~~client~~Client is furnished with his or her own personal hygiene and care items. These items are to be considered basic in meeting an individual's needs for hygiene and remaining healthy. Any additional items may be selected and purchased by the ~~client~~Client at his or her discretion.

6. There shall be adequate bathroom facilities for individuals to access without undue waiting or burden.

7. Each ~~client~~Client shall have access to telephones, both to make and to receive calls in privacy.

8.515.85.K COMPLAINTS AND GRIEVANCES

Each ~~client~~Client will have the right to voice grievances and recommend changes in policies and services to both the Department and/or the SLP provider. Complaints and grievances made to the Department shall be made in accordance with the grievance and appeal process in § 8.209.

8.515.85.M RECORDS

1. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, ~~§~~ Section 18, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to ~~C.R.S. §~~Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. Supportive Living Providers shall develop policies and procedures to secure ~~client~~Client information against potential identity theft. Confidentiality of medical records shall be maintained in compliance with 45 C.F.R. § 160.101, et seq.

3. All medical records for adults (persons eighteen (18) years of age or older) shall be retained for no less than six (6) years after the last date of service or discharge from the SLP. All medical records for minors shall be retained after the last date of service or discharge from the SLP for the period of minority plus six (6) years.

8.515.85.N REIMBURSEMENT

1. SLP services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.

2. The methodology for calculating the per diem rate shall be based on a weighted average of ~~client~~Client acuity scores.

3. The Department shall establish a maximum allowable room and board charge for ~~client~~Clients in the SLP. Increases in payment shall be permitted in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises grant amounts.

   a. Room and board shall not be a benefit of HCBS-BI residential services. ~~Client~~Clients shall be responsible for room and board in an amount not to exceed the Department-established rate.

8.515.85.O CALCULATION OF CLIENT PAYMENT (PETI)

1. When a ~~client~~Client has been determined eligible for HCBS-BI under the 300% income standard§, the State may reduce Medicaid payment for SLP residential services. The case manager shall calculate the ~~client~~Client payment (PETI) for 300% eligible HCBS-BI ~~client~~Clients according to the following procedures:

   a. For 300% eligible ~~client~~Clients who receive residential services, the case manager shall complete a State-prescribed form which calculates the ~~client~~Client payment according to the following procedures:

      i. An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the ~~client~~Client's gross income to be used as the ~~client~~Client maintenance allowance, from which the state-prescribed HCBS residential services room and board amount shall be paid, and

      ii. For an individual with financial responsibility for others:

         1) If the individual is financially responsible for only a spouse, an amount equal to the state Aid to the Needy Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the ~~client~~Client's gross income; or

         2) If the individual is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding income from part-time employment earnings of a dependent child, as defined at § 8.100.1, who is either a full-time student or a part-time student§) shall be deducted from the ~~client~~Client's gross income.

      iii. Expenses incurred for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the ~~client~~Client's gross income as follows:

         1) If health insurance coverage is documented in the eligibility system, health insurance premiums, deductible and co-insurance charges, and

2) Necessary dental care not to exceed amounts equal to actual expenses incurred, and

3) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred, and

4) Medications, with the following limitations:

a) The need for such medications shall be documented in writing by the attending physician. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change in medications.

b) The cost for medications which may be purchased with the ~~client~~Client's Medicaid Identification Card shall not be allowed as deductions.

c) The cost for medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

d) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

e) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

5) The cost for other necessary medical or remedial care shall be deducted from the ~~client~~Client's gross income, with the following limitations:

a) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.

b) The cost for any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

6) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

7) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or

medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

iv. Any remaining income shall be applied to the cost of the SLP residential services, as described at § 8.515.85.C, and shall be paid by the ~~client~~Client directly to the facility; and

v. If there is still income remaining after the entire cost of residential services are paid from the ~~client~~Client's income, the remaining income shall be kept by the ~~client~~Client and may be used as additional personal needs or for any other use that the ~~client~~Client desires, except that the residential service provider shall not charge more than the Medicaid rate for that service.

b. Case managers shall inform HCBS-BI ~~client~~Clients receiving residential services of their ~~client~~Client payment obligation on a form prescribed by the state at the time of the first assessment visit, by the end of each plan period. Whenever there is a significant change in the ~~client~~Client payment amount that affects the ~~client~~Client's payment obligation, the case manager must inform the ~~client~~Client of the change in payment within ten (10) working days,.

i. Significant change is defined as fifty dollars ($50) or more.

ii. Copies of ~~client~~Client payment forms shall be kept in the ~~client~~Client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request under § 8.515.7, or if requested by the state for monitoring purposes.

8.516.10 INDEPENDENT LIVING SKILLS TRAINING

A. DEFINITIONS

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

2. ILST program service plans are plans that describe the ILST services necessary to enable the ~~client~~Client to independently sustain himself/herself physically, emotionally, and economically in the community. This plan is developed with the ~~client~~Client and the provider.

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

4. Person-Centered Care Plan is a plan of care created by a process that is driven by the individual and may also include people chosen by the individual, as well as the appropriate health care professional and the designated independent living ILST trainer(s). It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents

~~client~~Client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the ~~client~~Client needs to function safely in the community. This plan is developed by the ~~client~~Client with the case management agency.

B. INCLUSIONS

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

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

   b. Medication supervision and reminders;

   c. Household management;

   d. Time management skills training;

   e. Safety awareness skill development and training;

   f. Task completion skill development and training;

   g. Communication skill building;

   h. Interpersonal skill development;

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

   j. Recreation, including leisure and community integration activities;

   k. Sensory motor skill development;

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

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

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

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

C. PROVIDER CERTIFICATION STANDARDS

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

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

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

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

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

i. Occupational Therapist;

ii. Physical Therapist;

iii. Registered Nurse;

iv. Speech Language Pathologist;

v. Psychologist;

vi. Neuropsychologist;

vii. Medical Doctor;

viii. Licensed Clinical Social Worker;

ix. Licensed Professional Counselor.

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

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

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

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

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

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

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

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

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

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

i. Person-centered care approaches; and

ii. HIPAA and ~~client~~Client confidentiality; and

iii. Basics of brain injury including at a minimum;

1. Basic neurophysiology; and

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

3. Epidemiology of brain injury; and

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

5. Best practices in brain injury recovery; and

6. Screening for a history of brain injury.

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

v. Basic safety and de-escalation techniques; and

vi. Training on community and public resource availability; and

vii. Understanding of current brain injury recovery guidelines; and

viii. First aid.

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

i. Cultural awareness; and

ii. Updates on brain injury recovery guidelines; and

iii. Updates on resource availability.

D. REIMBURSEMENT

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

8.516.30 TRANSITIONAL LIVING

A. DEFINITIONS

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

2. Program services include but are not limited to assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household.

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

B. INCLUSIONS

1. All services must be documented in an approved plan of care and be prior authorized by the Department.

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

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

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

C. EXCLUSIONS

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

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

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

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

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

D. CERTIFICATION STANDARDS

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

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

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

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

4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis.

5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

2. Clients, families, medical proxies, or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

3. Understanding that ~~client~~Clients of transitional living programs frequently experience behavior which may be a danger to himself/herself or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a ~~client~~Client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.

4. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve ~~client~~Clients for whom they lack adequate resources to ensure safety of program participants and staff.

5. Upon entry into the program, discharge planning shall begin with the ~~client~~Client and family. Transitional living programs shall work with the ~~client~~Client and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services.

6. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

7. During daytime hours, the ratio of staff to ~~client~~Clients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.

8. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Department.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service-~~-~~related profession plus three years of experience providing direct services to individuals with brain injury. A bachelor's degree with five years of experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.

2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the ~~client~~Client. These staff members will have successfully completed a training program of at least 40 hours duration.

3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.

4. The operator, staff, and volunteers who provide direct ~~client~~Client care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from impatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two-~~-~~week period following admission.

3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.

5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

6. All transitional services must utilize licensed psychologists win two years of experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the ~~client~~Client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.

7. Programs shall have a process verified in writing by which a ~~client~~Client is made aware of the process for filing a grievance. Complaints by the ~~client~~Client or family shall be handled via telephone or direct contact with the ~~client~~Client or family.

8. Customer satisfaction surveys will be regularly performed and reviewed.

9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.

10. Client safety in the community will be assessed: safety status and recommendations will be documented.

11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.

2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the acuity-based per diem reimbursement rate established by the Department and will not bill the ~~client~~Client in excess of his/her SSI payment or $400 per month, whichever is less for room and board charges.

All transitional living services shall be prior authorized through submission to the Department. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond six months duration must be reauthorized with treatment plan justification and shall be submitted through the reconsideration process established by the.

8.516.40 BEHAVIORAL PROGRAMMING

A. DEFINITION

Behavioral programming and education is an individually developed intervention designed to decrease/control the ~~client~~Client's severe maladaptive behaviors which, if not modified, will interfere with the individuals ability to remain integrated in the community.

B. INCLUSIONS

1. Programs should consist of a comprehensive assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the person's environment.

2. Behavioral programs may be provided in the community or in the ~~client~~Client's residence unless the residence is a transitional living center which provides behavioral intervention as a treatment component

3. All behavioral programming must be documented in the plan of care and reauthorized after 30 units of service with the Brain Injury Program Coordinator.

C. CERTIFICATION STANDARDS

1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a health care professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters level Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of behavioral management concepts.

2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with brain injury if their work experience does not include at least one year of same.

D. REIMBURSEMENT

Behavioral programming must be documented on the ~~client~~Client's care plan and prior authorized through the State Brain Injury Program Coordinator. Behavioral programming services will be paid on an hourly basis as established by the Department

8.516.50 COUNSELING

A. DEFINITIONS

Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries.

B. INCLUSIONS

1. Counseling is available to the program participant's family in conjunction with the ~~client~~Client if they: a) have a significant role in supporting the ~~client~~Client or b) live with or provide care to the ~~client~~Client. “Family” includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the waiver participant.

2. Services may be provided in the waiver participant's residence, in community settings, or in the provider's office.

3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.

4. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department as directed by certification standards listed below.

5. Family training/counseling must be carried out for the direct benefit of the ~~client~~Client of the HCBS-BI program.

6. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the plan of care~~,~~ and shall include updates as may be necessary to safely maintain the individual at home.

7. Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

1. Family training is not available to individuals who are employed to care for the recipient.

D. CERTIFICATION STANDARDS

1. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker. Certified Rehabilitation Counselor. Licensed Professional Counselor, or Licensed Clinical Psychologist.

2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years of experience in providing counseling to individuals with brain injury and their families.

3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling, Individual Counseling, and Group Counseling.

8.516.60 SUBSTANCE ABUSE COUNSELING

A. DEFINITION

Substance abuse programs are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the water participant which, if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

B. INCLUSIONS

1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program

2. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver participant, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons if directly involved in the support system of the ~~client~~Client, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager.

3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall he submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

Inpatient treatment is not a covered benefit.

D. CERTIFICATION STANDARDS

1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing.

2. Programs must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury.

3. Counselors should be certified at the Certified Addiction Counselor II level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any individual with a brain injury or their family members. A recommended training curriculum will include a three-~~-~~day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present). Individual Counseling, and Group Counseling.

8.516.70 RESPITE CARE

A. DEFINITIONS

1. Respite care means services provided to an eligible ~~client~~Client on a short-term basis because of the absence or need for relief of those persons normally providing the care.

2. Respite care provider means a Class I nursing facility, an alternative care facility or an employee of a certified personal care agency which meets the certification standards for respite care specified below.

B. INCLUSIONS

1. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite ~~client~~Client, as ordered by the physician.

C. RESTRICTIONS

1. An individual ~~client~~Client shall be authorized for no more than a cumulative total of thirty (30) days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home and~~or~~ in a nursing facility.

A. A mix of delivery options is allowable ~~as long as~~if the aggregate amount of services is below thirty (30) days, or 720 hours, of respite care.

1. In home respite is limited to no more than eight (8) hours per day.

2. Nursing facility respite billed on a per diem.

2. Only those portions of the facility that are Medicaid certified for nursing facility services may be utilized for respite ~~client~~Clients.

D. CERTIFICATION STANDARDS AND PROCEDURES

1. Respite care standards and procedures for nursing facilities are as follows:

A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

B. The nursing facility does not have to maintain or hold open separately designated beds for respite ~~client~~Clients~~,~~ but may accept respite ~~client~~Clients on a bed available basis.

C. For each HCBS-BI respite ~~client~~Client, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the ~~client~~Client. The chart must identify the ~~client~~Client as a respite ~~client~~Client. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

D. An admission to a nursing facility under HCBS-BI respite does not require a new ULTC-100.2, a PASARR review, an AP-5615 form, a physical, a dietitian

assessment, a therapy assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

E. The nursing facility shall have written policies and procedures available to staff regarding respite care ~~client~~Clients. Such policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care ~~client~~Clients.

F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite ~~client~~Client's entry into the facility.

3. Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

E. REIMBURSEMENT

1. Respite care reimbursement to nursing facilities shall be as follows:

A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-BI claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full ~~twenty-four-hour~~twenty-four-hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

2. Respite care reimbursement to alternative care facilities shall be as follows:

A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-BI claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four-hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

3. Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

4. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI services shall not be reimbursed during the respite stay.

5. There shall be no reimbursement provided under this section for respite care in uncertified, congregate facilities.

8.517 HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY WAIVER

8.517.1 HCBS-SCI WAIVER SERVICES

8.517.1.A SERVICES PROVIDED

1. Adult Day Services
2. Complementary and Integrative Health Services
3. Consumer Directed Attendant Support Services (CDASS)
4. Electronic Monitoring
5. Home Delivered Meals
6. Home Modification
7. Homemaker Services
8. In-Home Support Services
9. Life Skills Training (LST)
10. Non-Medical Transportation
11. Peer Mentorship
12. Personal Care Services
13. Respite Care
14. Transition Setup

8.517.1.B DEFINITIONS OF SERVICES

1. Adult Day Services means services as defined at Section 8.491.
2. Complementary and Integrative Health Services means services as defined at Section 8.517.B.2.
3. Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.
4. Electronic Monitoring means services as defined at Section 8.488.
5. Home Delivered Meals means services as defined at Section 8.553.
6. Home Modification means services as defined at Section 8.493.
7. Homemaker Services means services as defined at Section 8.490.

8. In-Home Support Services means services as defined at Section 8.552.

9. Life Skills Training (LST) means services as defined at Section 8.553.

10. Non-Medical Transportation means services as defined at Section 8.494.

11. Peer Mentorship means services as defined at Section 8.553.

12. Personal Care Services means services as defined at Section 8.489.

13. Respite Care means services as defined at Section 8.492.

14. Transition Setup means services as defined at Section 8.553.

8.517.2 GENERAL DEFINITIONS

A. Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about beneficial physiologic and /or psychological changes.

B. Chiropractic Care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems.

C. Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.

D. Complementary and Integrative Health Provider means an individual or agency certified annually by the Department to have met the certification standards listed at Section 8.517.11.

~~D.~~E. Denver Metro Area means the counties of Adams, Arapahoe, Denver, Douglas, and Jefferson.

~~E.~~F. Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

~~F.~~G. Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

~~G.~~H. Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.

~~H.~~I. Medical Director means an individual that is contracted with the Department to provide oversight of the Complementary and Integrative Health Services and the program evaluation.

8.517.2.1 SPINAL CORD INJURY DEFINITION

A spinal cord injury is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Spinal cord injury unspecified
2. Complete lesion of spinal cord
3. Anterior cord syndrome
4. Central cord syndrome
5. Other specified spinal cord injury
6. Lumbar spinal cord injury without spinal bone injury
7. Sacral spinal cord injury without spinal bone injury
8. Cauda equina spinal cord injury without spinal bone injury
9. Multiple sites of spinal cord injury without spinal bone injury
10. Unspecified site of spinal cord injury without spinal bone injury
11. Injury to cervical nerve root
12. Injury to dorsal nerve root
13. Injury to lumbar nerve root
14. Injury to sacral nerve root
15. Injury to brachial plexus
16. Injury to lumbosacral plexus
17. Injury to multiple sites of nerve roots and spinal plexus
18. Injury to unspecified site of nerve roots and spinal plexus
19. Injury to cervical sympathetic nerve excluding shoulder and pelvic girdles
20. Injury to other sympathetic nerve excluding shoulder and pelvic girdles
21. Injury to other specified nerve(s) of trunk excluding shoulder and pelvic girdles
22. Injury to unspecified nerve of trunk excluding shoulder and pelvic girdles
23. Paraplegia
24. Paraplegia, Unspecified
25. Paraplegia, Complete
26. Paraplegia, Incomplete
27. Quadriplegia/Tetraplegia/Incomplete – unspecified

28. Quadriplegia – C1-C4/Complete

29. Quadriplegia – C1-C4/Incomplete

30. Quadriplegia – C5-C7/Complete

31. Quadriplegia – C5-C7/Incomplete

8.517.3 LEGAL BASIS

The ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver is created upon authorization of a waiver of the state-wideness requirement contained in Section 1902(a)(1) of the Social Security Act (42 U.S.C. Section 1396a); and the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act (42 U.S.C. Section 1396a). Upon approval by the United States Department of Health and Human Services, this waiver is granted under Section 1915(c) of the Social Security Act (42 U.S.C. Section 1396n

8.517.4 SCOPE AND PURPOSE

8.517.4.A. The ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver provides assistance to individuals with spinal cord injuries in the Denver Metro Area that require ~~long term~~long-term supports and services in order to remain in a community setting.

8.517.4.B. The HCBS-SCI waiver provides an opportunity to study the effectiveness of Complementary and Integrative Health Services and the impact the provision of these service may have on the utilization of other HCBS-SCI waiver and/or acute care services.

8.517.4.C. An independent evaluation shall be conducted no later than January 1, 2020 to determine the effectiveness of the Complementary and Integrative Health Services.

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall be offered only to individuals who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a diagnosis of Spinal Cord Injury. This diagnosis must be outlined in 8.517.2.1 and documented on the individual's Professional Medical Information Page (PMIP) and in the Uniform Long-t~~T~~erm Care 100.2 (ULTC 100.2) assessment tool.

3. Individuals shall have been determined to have a significant functional impairment as evidenced by a comprehensive functional assessment using the ULTC 100.2 assessment tool that results in at least the minimum scores required per Section 8.401.1.15.

4. Individuals shall reside in the Denver Metro Area as evidenced by residence in one of the following counties:

   a. Adams;

b. Arapahoe;

c. Denver;

d. Douglas; or

e. Jefferson

8.517.5.B FINANCIAL ELIGIBILITY

Individuals must meet the financial eligibility requirements specified at Section 8.100.7 LONG-TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.517.5.C LEVEL OF CARE CRITERIA

Individuals shall require ~~long term~~long-term support services at a level of care comparable to services typically provided in a nursing facility or hospital.

8.517.5.D NEED FOR HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY (HCBS-SCI) WAIVER SERVICES

1. Only individuals that currently receive ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services, or that have agreed to accept HCBS-SCI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-SCI waiver.

   a. Case management is not an HCBS-SCI service and shall not be used to satisfy this requirement.

   b. The desire or need for any Medicaid services other than HCBS-SCI waiver services, as listed at Section 8.517.1, shall not satisfy this eligibility requirement.

2. Individuals that have not received at least one (1) HCBS-SCI waiver service for a period greater than 30 consecutive days shall be discontinued from the waiver.

8.517.5.E EXCLUSIONS

1. Individuals who are residents of nursing facilities or hospitals are not eligible to receive ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services.

2. HCBS-SCI ~~client~~Clients that enter a nursing facility or hospital may not receive HCBS-SCI waiver services while admitted to the nursing facility or hospital.

   a. HCBS-SCI ~~client~~Clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-SCI program.

   b. HCBS-SCI ~~client~~Clients entering a nursing facility for Respite Care as an HCBS-SCI service shall not be discontinued from the HCBS-SCI program.

8.517.5.F COST CONTAINMENT AND SERVICE ADEQUACY

1. Individuals shall not be eligible for the ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver if the

case manager determines any of the following during the initial assessment and service planning process:

a. The individual's needs cannot be met within the Individual Cost Containment Amount.

b. The individual's needs are more extensive than HCBS-SCI waiver services ~~are able to~~ can support and/or that the individual's health and safety cannot be assured in a community setting.

2. Individuals shall not be eligible for the HCBS-SCI waiver at reassessment if the case manager determines the individual's needs are more extensive than HCBS-SCI waiver services are able to support and/or that the individual's health and safety cannot be assured in a community setting.

3. Individuals may be eligible for the HCBS-SCI waiver at reassessment if the case manager determines that HCBS-SCI waiver services are able to support the individual's needs and the individual's health and safety can be assured in a community setting.

a. If the case manager expects that the services required to support the individual's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the individual's request for services is appropriate and justifiable based on the individual's condition.

i) Individuals may request of the case manager that existing services remain intact during this review process.

ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:

1) The ~~client~~Client's appeal rights pursuant to Section 8.057; and

2) Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

8.517.6 WAITING LIST

1. The number of ~~client~~Clients who may be served through the ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver during a fiscal year may be limited by the federally approved waiver.

2. Individuals determined eligible for the HCBS-SCI waiver who cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

3. The waiting list shall be maintained by the Department.

4. The case manager shall ensure the individual meets all eligibility criteria as set forth at Section 8.517.5 prior to notifying the Department to place the individual on the waiting list.

5. The date the case manager determines an individual has met all eligibility requirements as set forth at Section 8.517.5 is the date the Department will use for the individual's placement on the waiting list.

6. When an eligible individual is placed on the waiting list for the HCBS- SCI waiver, the case manager shall provide a written notice of the action in accordance with section 8.057 et seq.

7. As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for the HCBS-SCI waiver in the order of the individual's placement on the waiting list

8. When an opening for the HCBS-SCI waiver becomes available the Department will provide written notice to the Case Management Agency.

9. Within ten business days of notification from the Department that an opening for the HCBS-SCI waiver is available the Case Management Agency shall:

   a. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

   b. Update the existing functional level of care assessment in the official ~~client~~Client record if less than six months has elapsed since the date of the previous assessment.

   c. Reassess for eligibility criteria as set forth at 8.517.5.

   d. Notify the Department of the individual's eligibility status.

8.517.7 START DATE FOR SERVICES

8.517.7.A. The start date of eligibility for ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall not precede the date that all of the requirements at Section 8.517.5, have been met. The first date for which HCBS-SCI waiver services may be reimbursed shall be the later of the following:

1. The date at which financial eligibility is effective.

2. The date at which the level of care and targeting criteria are certified.

3. The date at which the individual agrees to accept services and signs all necessary intake and service planning forms.

4. The date of discharge from the hospital or nursing facility.

8.517.8 CASE MANAGEMENT FUNCTIONS

8.517.8.A. The requirements at Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver.

8.517.9 PRIOR AUTHORIZATION OF SERVICES

8.517.9.A. All ~~Home and Community-Based Services~~Home and Community-based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services must be prior authorized by the Department or its agent.

8.517.9.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.517.9.C. Claims for services are not reimbursable if:

1. Services are not consistent with the ~~client~~Client's documented medical condition and functional capacity;

2. Services are not medically necessary or are not reasonable in amount, scope, frequency, and duration;

3. Services are duplicative of other services included in the ~~client~~Client's Service Plan;

4. The ~~client~~Client is receiving funds to purchase services; or

5. Services total more than 24 hours per day of care.

8.517.9.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

8.517.9.E. Payment for HCBS-SCI waiver services is also conditional upon:

a. The ~~client~~Client's eligibility for HCBS-SCI waiver services;

b. The provider's certification status; and

c. The submission of claims in accordance with proper billing procedures.

8.517.9.F. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulation and necessary to meet the ~~client~~Client's needs.

8.517.9.G. Services requested on the PAR shall be supported by information on the Long-t~~-T~~erm Care Service Plan, the ULTC-100.2, and written documentation from the income maintenance technician of the ~~client~~Client's current monthly income.

8.517.9.H. The PAR start date shall not precede the start date of HCBS-SCI eligibility in accordance with Section 8.517.7.

8.517.9.I. The PAR end date shall not exceed the end date of the HCBS-SCI eligibility certification period.

8.517.10 PROVIDER AGENCIES

8.517.10.A. HCBS-SCI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

8.517.11 COMPLEMENTARY AND INTEGRATIVE HEALTH SERVICES

Complementary and Integrative Health Services are limited to Acupuncture, Chiropractic Care, and Massage Therapy as defined at Section 8.517.2.

8.517.11.A. Inclusions

1. Acupuncture used for the treatment of conditions or symptoms related to the ~~client~~Client's spinal cord injury.

2. Chiropractic Care used for the treatment of conditions or symptoms related to the ~~client~~Client's spinal cord injury.

3. Massage Therapy used for the treatment of conditions or symptoms related to the ~~client~~Client's spinal cord injury.

8.517.11.B. Exclusions / Limitations

1. Complementary and Integrative Health Services shall be provided only for the treatment of conditions or symptoms related to the ~~client~~Client's spinal cord injury.

2. Complementary and Integrative Health Services shall be limited to the ~~client~~Client's assessed need for services as determined by the Complementary and Integrative Health Provider and documented in the Complementary and Integrative Health Care Plan.

3. Complementary and Integrative Health Services shall be provided in an approved outpatient setting in accordance with 8.517.11.C.2 or in the ~~client~~Client's residence.

4. Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.

5. Clients receiving Complementary and Integrative Health Services shall participate in an independent evaluation to determine the effectiveness of the services.

6. The Complementary and Integrative Health Services benefit is limited as follows:

   a. A ~~client~~Client may receive each of the three individual Complementary and Integrative Health Services on a single date of service.

   b. A ~~client~~Client shall not receive more than four (4) units of each individual Complementary and Integrative Health Service on a single date of service.

   c. A ~~client~~Client shall not receive more than 204 units of a single Complementary and Integrative Health service during a 365-~~-~~day certification period.

   d. A ~~client~~Client shall not receive more than 408 combined units of all Complementary and Integrative Health Services during a 365-~~-~~day certification period.

8.517.11.C. Certification Standards

1. Organization and Staffing

   a. Complementary and Integrative Health Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.

   b. Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (Section 12-29.5-101, C.R.S.) and have at least three (3) years' experience practicing Acupuncture at a rate of 520 hours per year; or at least two (2) years' experience practicing acupuncture at a rate of 520 hours per year AND at least one (1) year of experience working with individuals with spinal cord injuries or other ~~long~~

~~term~~long-term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using acupuncture.

c. Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (Section 12-33-101, C.R.S.) and have at least three (3) years' experience practicing Chiropractic Care at a rate of 520 hours per year; or at least two (2) years' experience practicing Chiropractic Care at a rate of 520 hours per year AND at least one (1) year of experience working with individuals with spinal cord injuries or other ~~long term~~long-term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using chiropractic care.

d. Massage Therapists shall be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (Section 12-35.3-101, C.R.S.) and have at least three (3) years' experience practicing Massage Therapy at a rate of 520 hours per year; or at least two (2) years' experience practicing massage therapy at a rate of 520 hours per year AND at least (1) year of experience working with individuals with spinal cord injuries or other ~~long term~~long-term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using massage therapy.

2. Environmental Standards for Complementary and Integrative Health Services provided in an outpatient setting.

a. Complementary and Integrative Health Providers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. They shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.

b. Policies shall be developed and procedures implemented for the effective control of insects, rodents, and other pests.

c. All wastes shall be disposed in compliance with local, state and federal laws.

d. A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.

e. Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.

f. Outpatient settings shall be constructed and maintained to ensure access and safety.

g. Outpatient settings shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.

3. Failure to comply with the requirements of this rule may result in the revocation of the Complementary and Integrative Health Provider certification.

8.519 Case Management

8.519.1 Definitions

A. Adverse Action means a denial, reduction, termination, or suspension from a long-term service and support program or service.

B. Agency Applicant means an entity seeking approval to be a provider of case management services for Home and Community-Based Services.

C. Algorithm means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Clients into one of six support levels in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community-Based Services- Supported Living Services (HCBS-SLS) waivers.

D. Authorized Representative means an individual designated by a Client or by the parent or guardian of the Client, if appropriate, to assist the Client in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined in Section 8.510.1.

E. Business Day means any day in which the state is open and conducting business, but shall not include Saturday, Sunday, or any day in which the state observes on of the holidays listed in Section 24-11-101(1), C.R.S.

F. Case Manager means a person who provides case management services and meets all regulatory requirements for Case Managers.

G. Case Management means the assessment of an individual's needs receiving long-term services and supports, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of services effectiveness, and the periodic reassessment of such individual's needs.

H. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for specific Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

I. Certification means the process by which an agency is approved by the Department to provide case management which includes the submission and approval of a Medicaid Provider Agreement along with submission of verification that the agency meets the qualifications as set forth in Section 8.519.

J. Client means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

K. Client Representative means a person who is designated by the Client to act on the Client's behalf. A Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

L. Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting

Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

M. Comprehensive Assessment means an initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support.

N. Conflict-Free Case Management means, pursuant to 42 CFR § 441.301(c)(1)(vi), case management services provided to a Client enrolled in a Home and Community-Based Services waiver that are provided by a Case Management Agency that is not the same agency that provides services and supports to that person.

O. Corrective Action Plan means a written plan by the CMA, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

P. Critical Incident means incidents or allegations involving Clients receiving services to include mistreatment, abuse, neglect, exploitation, illness/injury, death, damage to consumer's property/theft, medication management issues, criminal activity, unsafe housing/displacement, and missing persons.

Q. Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.

R. Developmental Delay means as defined in Section 8.600.4.

S. Developmental Disability means as defined in Section 8.600.4.

T. Executive Director means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

U. Financial Eligibility means the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources, if applicable.

V. Guardian means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

W. Guardian ad litem or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in article 33 of title 22, C.R.S.

X. Home and Community-bBased Services (HCBS) waivers means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires an institutional Level of Care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

Y. Incident means an injury to a person receiving services; lost or missing persons receiving services; medical emergencies involving persons receiving services; hospitalizations of persons receiving services; death of persons receiving services; errors in medication administration;

incidents or reports of actions by persons receiving services that are unusual and require review; allegations of abuse, mistreatment, neglect, or exploitation; use of safety control procedures; use of emergency control procedures; and stolen personal property belonging to a person~~s~~ receiving services.

Z. Information Management System (IMS) means an automated data management system approved by the Department to enter case management information for each individual seeking or receiving ~~long term~~long-term services as well as to compile and generate standardized or custom summary reports.

AA. Interdisciplinary Team (IDT) means a group of people convened by a certified Case Management Agency that includes the person receiving services, the parent or guardian of a minor, guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as chosen by the person receiving services, who are assembled to work in a cooperative manner to develop or review the Service Plan.

BB. Legally Responsible Persons means the parent of a minor child, or the Client's spouse,

CC. Level of Care Determination means determining eligibility of an individual for a Long-Term Services and Supports (LTSS) program and determined by a Community Centered Board or Single Entry Point Agency.

DD. Level of Care Evaluation means a comprehensive evaluation with the individual seeking services and others chosen by the individual to participate and an evaluation by the Case Manager utilizing the Department prescribed tool, with supporting diagnostic information from the Client's medical provider, and to determine the Client's level of functioning for admission or continued stay in certain Long-Term Services and Supports (LTSS) programs.

EE. Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

FF. Medicaid Eligible means an applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

GG. Organized Health Care Delivery System (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-~~b~~Based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

HH. Parent means the biological or adoptive parent.

II. Performance and Quality Review means a review conducted by the Department or its contractor at any time but no less than the frequency as specified in the approved waiver application. To include a review of required case management services performed by the agency to ensure quality and compliance with all requirements. The agency shall provide all requested information and documents as requested by the Department or by its contractor.

JJ. Prior Authorization Requests (PAR) means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

KK. Professional Medical Information Page (PMIP) ~~means the medical information document signed by a licensed medical professional used as a component of the Level of Care evaluation to~~

~~determine the Client's needs for LTSS program.~~ means the medical information form signed by a licensed medical professional used to certify Level of Care.

LL. Provider for the purpose of this section means any person, group or entity approved to render services or provide items to a Client enrolled in an HCBS waiver program.

MM. Regional Center means a facility or program operated directly by the Department of Human Services which provides services and supports to Clients with intellectual and developmental disabilities.

NN. Retrospective Review means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the Service Plan and that the Case Management Agency complied with the requirements set forth in statute, waiver, and regulations.

OO. Service Plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.

PP. Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

QQ. Supports Intensity Scale (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with intellectual and developmental disabilities.

RR. Support Level means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

SS. Support Planning means the process of working with an individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate services providers based on the individual's assessment and knowledge of the individual and available community resources. Support planning includes informing the individual seeking or receiving services of his or her rights and responsibilities.

TT. Targeted Case Management (TCM) means case management services provided to ~~client~~Clients enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

UU. Waiver Services means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid state plan services.

8.519.5. Qualifications of Case Managers

8.519.5.A. All Home and Community--Based (HCBS) case managers must be employed by a certified Case Management Agency.

1. CMAs must maintain verification that employed case managers meet the qualifications set forth in these regulations.

8.519.5.B. The minimum requirement for HCBS Case Managers is a bachelor's degree in a human behavioral science or related field of study. If an individual does not meet the minimum requirement, the Case Management Agency shall request a waiver from the Department and demonstrate that the individual meets one of the following:

1. Experience working with long-term services and supports (LTSS) population, in a private or public agency, which can substitute for the required education on a year for year basis; or

2. A combination of LTSS experience and education, demonstrating a strong emphasis in a human behavioral science field.

3. A copy of the waiver request and Department approval shall be kept in the case manager's personnel file.

8.519.5.C. Case Managers may not:

1. Be related by blood or marriage to the Client.

2. Be related by blood or marriage to any paid caregiver of the Client.

3. Be financially responsible for the Client.

4. Be the Client's legal guardian, authorized representative, or be empowered to make decisions on the Client's behalf through a power of attorney.

5. Be a provider for the Client, have an interest in, or be employed by a provider for the same Client. Case Managers employed by a Case Management Agency that is operating under an exception approved by the Centers for Medicare and Medicaid Services (CMS) in the approved waiver application are exempt from this requirement.

8.519.5.D. Case Managers must complete the Department prescribed attestation form.

8.519.5.E. Case Managers must complete and document the following trainings within 120 days from the date of hire and prior to providing case management services independently:

1. Department prescribed assessment tool;

2. Service plan development and revision;

3. Referral for services, to include Medicaid and non-Medicaid;

4. Monitoring;

5. Case documentation;

6. Level of Care determination process;

7. Notices and appeals;

8. Incident and critical incident reporting;

9. Waiver requirements and services;

10. Person-centered approaches to planning and practice;

11. Interviewing and assessment skills; and

12. Regulations and state statutes for the LTSS program.

13. Department ~~Information Management Systems~~IMS Documentation

14. Mandatory Reporting

15. Participant Directed Training

16. Disability and Cultural Competency

17. Any Case Management training required by contract

8.519.6 Case Management Agency selection- To be implemented no later than January 1, 2021

8.519.6.A. Clients have the ability to change their Case Management Agency at any time, with the exception of initial enrollment into a waiver.

1. Clients must remain with the initial chosen Case Management Agency for at least 60 calendar days or until the service plan is developed, whichever is sooner.

8.519.6.B. At the time the Client has met all eligibility requirements for an HCBS waiver the Community Centered Board, shall within two (2) business days send a referral to the Department's contractor to assist the Client in selecting a CMA.

1. The Department's contractor shall contact the Client within two (2) business days from the date of referral from the CCB.

   a. The Client, or the Client's guardian, shall inform the Department's contractor of their choice of Case Management Agency.

   b. The Department's contractor shall assist the Client in selecting a CMA when necessary, which may include, but is not limited to:

      i. Providing a list of qualified CMAs.

      ii. Providing the Department's webpage address and information on how to search for a CMA.

      iii. Providing information regarding the qualified CMAs based on the Client's preferences.

      iv. In addition to other assistance as requested or needed by the Client.

2. The Department's contractor shall notify the selected CMA within two (2) business days from the date of selection by the Client.

a. The Departments contractor shall send a letter to the Client with the following information:

i. The selected CMA, address and contact information;

ii. Information about the Client's right to choose a CMA; and

iii. Contact information for the Department's contactor.

3. The selected CMA shall contact the Client within two (2) business days from notification of selection to confirm the choice and schedule a meeting to develop the Service Plan.

8.519.6.C Case Management Agency transfer

1 When a Client wishes to change their CMA, the Client must notify the current CMA or contact the Department's contractor directly.

a. The CMA shall notify the Department's contractor that the Client would like to change their CMA if the Client did not notify the contractor directly.

b The Department's contractor shall contact the Client within two (2) business days from the date of referral from the CMA or notification from the Client.

i. When the Client seeking case management services and/or their guardian, as appropriate, knows which approved CMA the Client wishes to select, the Client will inform the Department's contractor of their choice.

ii. When the Client seeking case management services and/or their guardian, as appropriate, does not know which approved CMA the Client wishes to select, the Department's contractor shall assist the Client in the selection of a CMA which may include, but is not limited to:

1. Providing a list of qualified CMAs.

2. Providing the Department's webpage address and information on how to search for a CMA.

3. Providing information regarding the qualified CMAs based on the Client's preferences.

4. Other assistance as requested or needed by the Client

iii. The Department's contractor shall notify the selected CMA within two (2) business days from the date of selection by the Client. The Department's contractor shall also send a letter to the Client with the following information:

1. The selected CMA;

2. Contact information for the CMA;

3. Information about the right to choose a CMA; and

4. Contact information for the Department's contractor.

iv. The selected CMA shall contact the Client within two (2) business days from notification of selection to confirm the choice and review service plan and any changes necessitated by the transfer.

v. The transferring CMA shall continue to provide case management services until the new CMA has been assigned in the Department's prescribed system and contacted the Client in accordance with 8.519.6.B(3).

8.519.7 Functions of Case Management Agencies for HCBS-CES, HCBS-CHRP, HCBS-DD, and HCBS-SLS

8.519.7.A. Case Management Agencies shall comply with the regulations at Sections 8.500 et seq., 8.503 et seq., 8.600 et seq. and 8.760 et seq.

8.519.7.B. The Case Management Agency chosen by the Client is responsible for providing case management services.

8.519.7.C. Case Management Agencies shall establish agency written procedures sufficient to execute case management services according to the provisions of these regulations. Such procedures shall include, but are not limited to:

1. Comprehensive assessment and periodic reassessment of a Client's needs;

2. Development and periodic revision of Client Service Plans;

3. Referral and related activities;

4. Monitoring;

5, The authorization and purchase of services and supports;

6. Services and support coordination;

7. Any safeguards necessary to prevent conflict of interest between case management and direct services provision; and

8. Denial and discontinuation of services.

8.519.7.D. Case Management Agencies shall have written procedures concerning the exercise and protection of Client rights pursuant to Sections 25.5-10-218 through 231, C.R.S.

8.519.7.E. Case Management Agencies shall have written procedures for Clients to dispute agency decisions, adverse actions, or actions of the agency's employees or contractors. Disputes may be filed by the Client, or parent of a minor Client, the Client's guardian, advocate, or the Client's authorized representative if within the scope of his/her duties. Agency procedures shall meet the requirements of Section 8.605.5. The agency shall offer and provide interpretation or translation services in languages other than English, and through such other modes of communication as may be necessary.

8.519.8 Compliance

8.519.8.A. Pursuant to Section 25.5-10-208 (4), C.R.S., upon a determination by the executive director or designee that services and supports have not been provided in accordance with the program or financial administration standards contained in these rules, the executive director or

designee may reduce, suspend, or withhold payment to a Case Management Agency from which the Department purchases services or supports directly.

8.519.8.B. Prior to initiating action to reduce, suspend, or withhold payment to a Case Management Agency for failure to comply with Department regulations, the executive director or designee shall provide written notice which must specify the reasons for the action and the actions necessary to achieve compliance.

8.519.8.C. The executive director or designees may revoke the Case Management Agency's certification upon a finding that the agency is in violation of provisions of Section 25.5-10-209.5, C.R.S, other state or federal laws, or these rules.

8.519.9 Payment for Case Management Services

8.519.9.A. Targeted case management services are only reimbursed for Clients enrolled in the HCBS-CES, HCBS-CHRP, HCBS-DD, HCBS-SLS waivers, and only if the services are in compliance with the requirements set forth at Section 8.760 et seq.

8.519.10 Case Management Payment Liability

8.519.10.A. Failure to prepare the service plan and prior authorization or failure to submit the service plan forms in accordance with Department policies and procedures shall result in the denial of reimbursement for services authorized retroactive to first date of service. The Case Management Agency and/or providers may not seek reimbursement for these services from the Client receiving services.

B. If the Case Management Agency causes a Client enrolled in HCBS waiver services to have a break in payment authorization, the agency will ensure that all services continue and will be solely financially responsible for any losses incurred by service providers until payment authorization is reinstated.

8.519.11 Case Management Services

8.519.11.A. Clients must be determined eligible for an HCBS waiver specific for individuals with Intellectual or Developmental Disabilities by a Community Centered Board prior to receiving case management services.

8.519.11.B. Case management services include the following:

1. Assessment: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support. Assessment activities include:

    a. Obtaining Client history;

    b. Identifying the Client's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers and educators, as necessary to form a complete assessment of the Client.

2. Service plan development and revision~~:~~ occurs no less than annually or as a warranted by the Client's needs or change in condition, at a time and location convenient for the Client with the Client and others chosen by the Client. The Case Manager shall complete

and review a service plan for each Client enrolled in the HCBS-CES, HCBS-DD, and HCBS-SLS waivers.

a. The service plan at minimum shall:

   i. Identify needs, personal goals, preferences, unique strengths, abilities, desires, health and safety, and risk factors;

   ii. Be in accordance with the Department's regulations, policies and procedures;

   iii. Identify the specific services and supports appropriate to meet the needs of the eligible Client, and family, as applicable;

   iv. Document decisions made through the service planning process including, but not limited to, rights suspension/modifications, the existence of appropriate services and supports and the actions necessary for the plan to be achieved;

   v. Document the authorized services and supports funded by the Department and the date authorized services begin or the projected date of initiation;

   vi. Identify a contingency plan for how necessary supports will be provided in the event that the Client's family, caregiver, or direct HCBS waiver provider is unavailable due to an emergency situation or unforeseen circumstances;

   vii. Have a listing of the service plan participants and their relationship to the Client;

   viii. Contain a statement of agreement with the plan signed, physical or digital signature, by the Client or other such person legally authorized to sign on the Client's behalf; and

   ix. Be in effect for a period not to exceed one year without review and be reviewed and amended as determined by the Case Manager, Client, and others as applicable.

b. The service plan shall document that the Client has been offered a choice:

   i. In the Home and Community- -bBased Services or institutional care,

   ii. Of waiver services, including service delivery options, and

   iii. Of qualified providers.

c. The service plan shall contain documentation that the Client is aware of the conflict of interest in situations where the Case Management Agency is the only agency able to provide direct HCBS waiver services, as approved in the waiver application, and that the Client has been provided a complaint and grievance procedure.

d. The service plan development shall occur at times and locations chosen by the Client to include but not limited to the Client's place of residence, place of

service, or other appropriate setting as determined by the Client's needs or preferences.

e. Others chosen by the Client shall be provided notification at least ten (10) days prior to the service plan meeting, if possible.

f. Copies of the service plan shall be disseminated to all persons and providers involved in implementing the service plan including the Client, their legal guardian, authorized representative and parent(s) of a minor, and others as applicable. If requested, copies shall be made available prior to the provision of services or supports, or within a reasonable period of time not to exceed thirty (30) days from the development of the service plan and in accordance with these rules;

3. Referral: the Case Manager shall assist Clients to obtain needed HCBS waiver services or other programs and services, to include non-Medicaid services, which include making referrals to providers, scheduling appointments, and assisting with access to transportation as needed or requested by the Client.

4. Monitoring: the Case Manager shall ensure that Clients receive services in accordance with their Service Plan and monitor the quality of the services and supports provided to the Clients.

a. The frequency and level of monitoring shall meet the requirements of the waiver in which the Client is enrolled. At a minimum, monitoring shall occur at least once per quarter, face-to-face, in a place where services are delivered, and review the following for each Client:

i. The delivery and quality of services and supports identified in the service plan including ensuring that services are delivered in accordance with the scope, frequency, and duration documented in the service plan;

ii. The health, safety and welfare of Clients, including the provider agencies' procedures to address the Client's needs;

iii. The satisfaction with services and choice in providers;

iv. Services are being delivered in a way that promote a Client's ability to engage in self-determination, self- representation and self-advocacy;

v. Concerns or issues as they relate to provider agencies. The Case Manager shall contact the provider agency to coordinate, arrange, or adjust services to address and resolve quality issues or concerns;

vi. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or misutilization of any public assistance benefit and shall cooperate with the appropriate agency in any subsequent recovery process.

b. Upon Department approval, monitoring contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or ~~client~~Client (e.g. natural disaster, pandemic, etc.).

5. Remediation: the Case Manager shall identify and implement strategies to prevent and resolve problems with the delivery of services and supports.

8.519.16 Critical Incident Reporting

8.519.16.A. Case Management Agencies shall have a written policy and procedure for the recording, reviewing, and reporting of critical incidents. Critical i~~I~~ncident reporting is required when the following occurs:

1. Injury/Illness;

2. ~~Lost or missing Client~~Missing Person;

3. ~~Medical emergencies~~Criminal Activity;

4. ~~Hospitalizations~~Unsafe Housing/Displacement;

5. Death;

6. ~~Errors in medication administration~~Medication Management Issues;

7. ~~Incidents or reports of actions by Clients that are unusual and required review~~Other High Risk Issues ;

8. Allegations of abuse, mistreatment, neglect, or exploitation;

~~9. Use of safety control procedures;~~

~~10. Use of emergency control procedures; and,~~9

~~11~~. ~~Stolen personal property belonging to a Client receiving services~~Damage to Consumer's Property/Theft.

8.519.16.B. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the agency administrator or designee, Case Management Agency, and to the CCB ~~within 24 hours.~~

1. Case Managers shall comply with mandatory reporting requirements set forth at Section 18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102, C.R.S.

8.519.16.C. Case Managers shall report critical incidents in the State-Approved IMS within 24 hours of notification. Each report must include:

a. Incident type

i. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, C.R.S, Section 26-3.1-101, C.R.S, Section 16-22-102 (9) C.R.S, and Section 25.5-10-202 C.R.S.

~~Definitions for Mistreatment, Abuse, Neglect and Exploitation may found at~~

~~a. Refer to 26-3.1-101 C.R.S. for definitions of Mistreatme and Exploitation.~~

ii. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, other high-risk issues.

b. Date and time of incident;

c. Location of incident, including name of facility, if applicable;

d. Individuals involved.

e. Description of incident, and

f. Resolution of incident, if applicable.

g. Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.

~~Incident reports shall be placed in the Client's record.~~

8.519.16.D. Incident reports submitted to by a provider to the ~~shall be made available to the~~ CCB or, Case Management Agency~~ies~~ will be reviewed by the case manager, documented into the state IMS and entered as a critical incident if the incident meets critical incident reporting criteria. Incident reports are to be made available to the~~, and the~~ Department upon request.

8.519.18 Use of an Authorized Representative

8.519.18.A. Clients who are eligible for services and supports, the parent or guardian of a minor, or legal guardian of an adult, shall be informed at the time of enrollment and at each annual review of the service plan that they may designate an authorized representative. The designation of an authorized representative must occur with informed consent of the Client, or the parent or guardian of a minor, or legal guardian of an adult.

8.519.18.B. A designation of an authorized representative shall be in writing and specify the extent of the authorized representative's involvement in assisting the Client receiving services, in acquiring or utilizing services or supports available, and in safeguarding the Client's rights.

8.519.18.C. The written designation of an authorized representative shall be maintained in the Client's record and shall be reviewed annually.

8.519.18.D. The Client may withdraw their designation of an authorized representative at any time~~,~~ and must notify the Case Manager of the withdrawal.

8.520.5. Service Types

8.520.5.A. Nursing Services

1. Standard Nursing Visit

a. Those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards;

b. Those skilled nursing services provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws;

c. Standard Nursing Visits include but are not limited to:

i. 1st medication box fill (medication pre-pouring) of the week;

ii. 1st visit of the day; the remaining visits shall utilize brief nursing units as appropriate;

iii. Insertion or replacement of indwelling urinary catheters;

iv. Colostomy and ileostomy stoma care; excluding care performed by ~~client~~Clients;

v. Treatment of decubitus ulcers (stage 2 or greater);

vi. Treatment of widespread, infected or draining skin disorders;

vii. Wounds that require sterile dressing changes;

viii. Visits for foot care;

ix. Nasopharyngeal, tracheostomy aspiration or suctioning, ventilator care;

x. Bolus or continuous Levin tube and gastrostomy (G-tube) feedings, when formula/feeding needs to be prepared or more than 1 can of prepared formula is needed per bolus feeding per visit, ONLY when there is not an able or willing caregiver; and

xi. Complex Wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

2. Brief Nursing Visits

a. Brief nursing visits for established long-term home health ~~client~~Clients who require multiple visits per day for uncomplicated skilled tasks that can be completed in a shorter or brief visit (excluding the first regular nursing visit of the day)

b. Brief Nursing Visits include, but are not limited to:

i) Consecutive visits for two or more ~~client~~Clients who reside in the same location and are seen by the same Home Health Agency nurse, excluding the first visit of the day;

ii) Intramuscular, intradermal and subcutaneous injections (including insulin) when required multiple times daily, excluding the first visit of the day;

iii) Insulin administration: if the sole reason for a daily visit or multiple visits per day, the first visit of the week is to be treated as a standard nursing visit and all other visits of the week are to be treated as brief nursing visits.

iv) Additional visits beyond the first visit of the day where simple wound care dressings are the sole reason for the visit;

v) Additional visits beyond the first visit of the day where catheter irrigation is the sole reason for the visit;

vi) Additional visits beyond the first visit of the day where external catheterization, or catheter care is the sole purpose for the visit;

vii) Bolus Levin or G-tube feedings of one can of prepared formula excluding the first visit of the day, ONLY when there is no willing or able caregiver and it is the sole purpose of the visit;

viii) Medication box refills or changes following the first medication pre-pouring of the week;

ix) Other non-complex nursing tasks as deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate; or

x) A combination of uncomplicated tasks when deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate.

c. Ongoing assessment shall be billed as brief nursing visits unless the ~~client~~Client experiences a change in status requiring a standard visit. If a standard nursing visit is required for the assessment, the agency shall provide documentation supporting the need on the PAR form and on the Plan of Care for the Department or its Designee.

3. PRN Nursing Visits

a. May be standard nursing visits or brief nursing visits; and

b. Shall include specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

4. Nursing Service Limitations

a. Nursing assessment visits are not covered if provided solely to open or recertify the case for CNA services, physical, occupational, or speech therapy.

b. Nursing visits solely for recertifying a ~~client~~Client are not covered.

c. Nursing visits that are scheduled solely for CNA supervision are not covered.

d. Family member/caregivers, who meet the requirements to provide nursing services and are nurses credentialed by, and in active status with the Department of Regulatory Agencies, may be employed by the Home Health Agency to provide nursing services to a ~~client~~Client, but may only be reimbursed for services that exceed the usual responsibilities of the Family Member/Caregiver.

e. PRN nursing visits may be requested as standard nursing visits or brief nursing visits and shall include a physician's order with specific criteria and

circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

f. Nursing visits are not reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Behavioral Health Organization. Nursing visits for mentally ill ~~client~~Clients are reimbursed under Home Health Services for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

g. Medicaid does not reimburse for two nurses during one visit except when two nurses are required to perform a procedure. For this exception, the provider may bill for two visits, or for all units for both nurses. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

h. Nursing visits provided solely for the purpose of assessing or teaching are reimbursed by the Department only in the following circumstances:

i) Nursing visits solely for the purpose of assessing the ~~client~~Client or teaching the ~~client~~Client or the ~~client~~Client's unpaid family member/caregiver are not reimbursed unless the care is acute home health or long-term home health with acute episode, per Section 8.520.3, or the care is for extreme instability of a chronic medical condition under long-term home health, per Section 8.520.3. Long-term home health nursing visits for the sole purpose of assessing or teaching are not covered.

ii) When an initial assessment visit is ordered by a physician and there is a reasonable expectation that ongoing nursing or CNA care may be needed. Initial nursing assessment visits cannot be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

iii) When a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the ~~client~~Client or the ~~client~~Client's unpaid family member/caregiver how to perform the task, the visit is not considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the ~~client~~Client or unpaid family member/caregiver performing the task to verify that the task is being performed correctly is considered a visit that is solely for the purpose of assessing and teaching and is not covered.

iv) Nursing visits provided solely for the purpose of assessment or teaching cannot exceed the frequency that is justified by the ~~client~~Client's documented medical condition and symptoms. Assessment visits may continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific medical conditions or symptoms which are not stable or not resolved. Teaching visits may be as frequent as necessary, up to the maximum reimbursement limits, to teach the ~~client~~Client or the ~~client~~Client's unpaid family member/caregiver, and may continue only as long as needed to demonstrate understanding or to perform care, or until it is determined that the ~~client~~Client or unpaid family member/caregiver is unable to learn or to perform the skill being taught. The visit in which the nurse determines that there is no longer a need for assessment or teaching

shall be reimbursed if it is the last visit provided solely for assessment or teaching.

v) Nursing visits provided solely for the purpose of assessment or teaching are not reimbursed if the ~~client~~Client is capable of self-assessment and of contacting the physician as needed, and if the ~~client~~Client's medical records do not justify a need for ~~client~~Client teaching beyond that already provided by the hospital or attending physician, as determined and documented on the initial Home Health assessment.

vi) Nursing visits provided solely for the purpose of assessment or teaching cannot be reimbursed if there is an available and willing unpaid family member/caregiver who is capable of assessing the ~~client~~Client's medical condition and needs and contacting the physician as needed; and if the ~~client~~Client's medical records do not justify a need for teaching of the ~~client~~Client's unpaid family member/caregiver beyond the teaching already provided by the hospital or attending physician, as determined and documented on the initial Home Health assessment.

i. Nursing visits provided solely for the purpose of providing foot care are reimbursed by Medicaid only if the ~~client~~Client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the ~~client~~Client or unpaid family member/caregiver is not able or willing to provide the foot care.

j. Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit. The clinical record shall indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for foot care to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

i) Absent (not palpable) posterior tibial pulse;

ii) Absent (not palpable) dorsalis pedis pulse;

iii) Three of the advanced trophic changes:

1) Hair growth (decrease or absence),

2) Nail changes (thickening),

3) Pigmentary changes (discoloration),

4) Skin texture (thin, shiny), or

5) Skin color (rubor or redness);

iv) Claudication (limping, lameness);

v) Temperature changes (cold feet);

vi) Edema;

vii)Paresthesia ~~Parasthesia~~; or

viii) Burning.

k. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers are reimbursed only if:

i) The ~~client~~Client is not living in a licensed Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at ~~C.R.S.~~Section 25-1.5-301 C.R.S.;

ii) The ~~client~~Client is not physically or mentally capable of pre-pouring medications or has a medical history of non-compliance with taking medications if they are not pre-poured;

iii) The ~~client~~Client has no unpaid family member/caregiver who is willing or able to pre-pour the medications for the ~~client~~Client; and

iv) There is documentation in the ~~client~~Client's chart that the ~~client~~Client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular ~~client~~Client.

l. The unit of reimbursement for nursing services is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~Client care or treatment.

8.520.9.B. Special Reimbursement Conditions

1. Total reimbursement by the Department combined with third party liability and Medicare crossover claims shall not exceed Medicaid rates.

2. When Home Health Agencies provide Home Health Services in accordance with these regulations to ~~client~~Clients who receive Home and Community~~-~~ b~~B~~ased Services for the Developmentally Disabled (HCBS-DD), the Home Health Agency is reimbursed:

a. Under normal procedures for home health reimbursement if the ~~client~~Client resides in an Intermediate Care Facility for ~~the Intellectually Disabled~~Individuals with Intellectual Disabilities (ICF/I~~I~~D), or in IRSS host homes and settings; or

b. By the group home provider, if the ~~client~~Client resides in a GRSS, because the provider has already received Medicaid funding for the Home Health Services and is responsible for payment to the Home Health Agency.

3. Acute Home Health Services for Medicaid HMO ~~client~~Clients are the responsibility of the Medicaid HMO, including ~~client~~Clients who are also HCBS recipients.

4. Services for a dual eligible ~~client~~Client shall be submitted first to Medicare for reimbursement. All Medicare requirements shall be met and administrative processes exhausted prior to any dual eligible ~~client~~Client's claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except for the specific services listed in Section 8.520.0.E.4.a below for ~~client~~Clients which meet the criteria listed in Section 8.520.9.E.4.b below.

a. A Home Health Agency may bill only Medicaid without first billing Medicare if both of the following are true:

i) The services below are the only services on the claim:

1) Pre-pouring of medications;

2) CNA services;

3) Occupational therapy services when provided as the sole skilled service; or

4) Routine laboratory draw services.

ii) The following conditions apply:

1) The ~~client~~Client is stable;

2) The ~~client~~Client is not experiencing an acute episode; and

3) The ~~client~~Client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

b. The Home Health Agency shall maintain clear documentation in the ~~client~~Client's record of the conditions and services that are billed to Medicaid without first billing Medicare.

c. A Home Health Change of Care Notice or Advance Beneficiary Notice of Non-Coverage shall be filled out as prescribed by Medicare.

5. Services for a dually eligible long-term home health ~~client~~Client who has an acute episode shall be submitted first to Medicare for reimbursement. Medicaid may be billed if payment is denied by Medicare as a non-covered benefit and the service is a Medicaid benefit, or when the service meets the criteria listed in Section 8.520.9.E.4 above.

6. If both Medicare and Medicaid reimburse for the same visit or service provided to a ~~client~~Client in the same episode, the reimbursement is considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

a. Home Health Agencies shall return any payment made by Medicaid for such visit or service to the Department within sixty (60) calendar days of receipt of the duplicate payment.

8.520.9.C. Reimbursement for Supplies

1. A Home Health Agency shall not ask a ~~client~~Client to provide any supplies. A request for supplies from a ~~client~~Client may constitute a violation of Section 8.012, PROVIDERS PROHIBITED FROM COLLECTING PAYMENT FROM RECIPIENTS.

2. Supplies other than those required for practice of universal precautions which are used by the Home Health Agency staff to provide Home Health Services are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the physician as a benefit to the ~~client~~Client under Section 8.590, DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLES.

3. Supplies used for the practice of universal precautions by the ~~client~~Client's family or other informal caregivers are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the physician as a benefit to the ~~client~~Client under Section 8.590, DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES.

8.520.9.D. Restrictions

1. When the ~~client~~Client has Medicare or other third-party insurance, Home Health claims to Medicaid will be reimbursed only if the ~~client~~Client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.

2. When an agency provides more than one employee to render a service, in which one employee is supervising or instructing another in that service, the Home Health Agency shall only bill and be reimbursed for one employee's visit or units.

3. Any visit made by a nurse or therapist to simultaneously serve two or more ~~client~~Clients residing in the same household shall be billed by the Home Health Agency as one visit only, unless services to each ~~client~~Client are separate and distinct. If two or more ~~client~~Clients residing in the same household receive Medicaid CNA services, the services for each ~~client~~Client shall be documented and billed separately for each ~~client~~Client.

4. No more than one Home Health Agency may be reimbursed for providing Home Health Services during a specific plan period to the same ~~client~~Client, unless the second agency is providing a Home Health Service that is not available from the first agency. The first agency shall take responsibility for the coordination of all Home Health Services. Home and Community-~~B~~based Services, including personal care, are not Home Health Services.

5. Improper Billing Practices: Examples of improper billing include, but are not limited to:

   a. Billing for visits without documentation to support the claims billed. Documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the ~~client~~Client's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.076.2;

   b. Billing for unnecessary visits, or visits that are unreasonable in number, frequency or duration;

   c. Billing for CNA visits in which no skilled tasks were performed and documented;

   d. Billing for skilled tasks that were not medically necessary;

   e. Billing for Home Health Services provided at locations other than an eligible place of service, except EPSDT services provided with prior authorization; and

   f. Billing of personal care or homemaker services as Home Health Services.

6. A Home Health Agency that are also certified as a personal care/homemaker provider shall ensure that neither duplicate billing nor unbundling of services occurs in billing for Home Health Services and HCBS personal care services. Examples of duplicate billing and unbundling of services include:

   a. One employee makes one visit, and the agency bills Medicaid for a CNA visit, and also bills all of the hours as HCBS personal care or homemaker.

b. One employee makes one visit, and the agency bills for one CNA visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 1 hour plus the number of hours billed for HCBS personal care and homemaker.

c. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of CNA and personal care or homemaker services.

7. The Department may take action against the offending Home Health Agency, including termination from participation in Colorado Medicaid in accordance with 10 C.C.R. 2505-10, Section 8.076.

8.520.10 Compliance Monitoring Reviews

8.520.10.A. General Requirements

1. Compliance monitoring of Home Health Services may be conducted by state and federal agencies, their contractors and law enforcement agencies in accordance with 10 C.C.R. 2505-10, Section 8.076.

2. Home Health Agencies shall submit or produce all requested documentation in accordance with 10 C.C.R. 2505-10, Section 8.076.

3. Physician-signed Plans of Care shall include nursing or therapy assessments, current clinical summaries and updates for the ~~client~~Client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485. All sections of the form shall be completed. All therapy services provided shall be included in the Plan of Care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency.

4. Provider records shall document the nature and extent of the care actually provided.

5. Unannounced site visits may be conducted in accordance with ~~C.R.S.~~ Section 25.5-4-301(14)(b) C.R.S.~~.~~

6. Home Health Services which are duplicative of any other services that the ~~client~~Client has received funded by another source or that the ~~client~~Client received funds to purchase shall not be reimbursed.

7. Services which total more than twenty-four hours per day of care, regardless of funding source shall not be reimbursed.

8. Billing for visits or contiguous units which are longer than the length of time required to perform all the tasks prescribed on the care plan shall not be reimbursed.

9. Home Health Agencies shall not bill ~~client~~Clients or families of ~~client~~Client for any services for which Medicaid reimbursement is recovered due to administrative, civil or criminal actions by the state or federal government.

8.520.11 Denial, Termination, or Reduction in Services

8.520.11.A. When services are denied, terminated, or reduced by action of the Home Health Agency, the Home Health Agency shall notify the ~~client~~Client.

8.520.11.B. Termination of services to ~~client~~Clients still medically eligible for Coverage of Medicaid Home Health Services:

1. When a Home Health Agency decides to terminate services to a ~~client~~Client who needs and wants continued Home Health Services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the Home Health Agency shall give the ~~client~~Client, or the ~~client~~Client's designated representative/legal guardian, written advance notice of at least 30 business days. The attending physician and the Department's Home Health Policy Specialist shall also be notified.

2. Written notice to the ~~client~~Client, or ~~client~~Client's designated representative/legal guardian shall be provided in person or by certified mail~~,~~ and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services

3. The agency shall make a good faith effort to assist the ~~client~~Client in securing the services of another agency.

4. If there is indication that ongoing services from another source cannot be arranged by the end of the advance notice period, the terminating agency shall ensure ~~client~~Client safety by making referrals to appropriate case management agencies or County Departments of Social Services; and the attending physician shall be informed.

5. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the ~~client~~Client, Home Health Agency, staff, or when the ~~client~~Client has begun to receive Home Health Services through a Medicaid HMO.

8.535 PEDIATRIC PERSONAL CARE SERVICES

8.535.1 Pediatric Personal Care Services are provided in accordance with the provisions of Appendix A, which sets forth the coverage standards for the benefit.

8.540 PRIVATE DUTY NURSING SERVICES

8.550 HOSPICE BENEFIT

8.550.1 DEFINITIONS

A. Alternative Care Facility (ACF) means an assisted living residence that is enrolled as a Medicaid provider.

B. Assisted Living Residence means an assisted living residence as defined in 6 CCR 1011-1 Chapter 7~~VII~~.

C. Benefit Period means a period during which the ~~client~~Client has made an Election to receive hospice care defined as one or more of the following:

1. An initial 90-day period.

2. A subsequent 90-day period.

3. An unlimited number of subsequent 60-day periods.

The periods of care are available in the order listed and may be Elected separately at different times.

D. Certification means that the ~~client~~Client's attending physician and/or the Hospice Provider's medical director have affirmed that the ~~client~~Client is Terminally Ill.

E. ~~Client~~Client Record means a medical file containing the ~~client~~Client's Election of Hospice, eligibility documentation, and other medical records.

F. Department means the Colorado Department of Health Care Policy and Financing. The Department is designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

G. Election/Elect means the ~~client~~Client's written expression to choose Hospice care for Palliative and Supportive Medical Services. Home Care Services means Hospice Services that are provided primarily in the ~~client~~Client's home but may be provided in a residential facility and/or licensed or certified health care facility.

H. Hospice means a centrally administered program of palliative, supportive, and Interdisciplinary Team services providing physical, psychological, sociological, and spiritual care to Terminally Ill ~~client~~Clients and their families.

I. Hospice Provider means a Medicaid and Medicare-certified Hospice provider.

J. Hospice Services means counseling, certified nurse aide, personal care worker, homemaker, nursing, physician, social services, physical therapy, occupational therapy, speech therapy, and trained volunteer services.

K. Interdisciplinary Team means a group of qualified individuals, consisting of at least a physician, registered nurse, clergy, counselors, volunteer director or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice ~~client~~Clients and their families.

L. Intermediate Care Facility for ~~People~~ Individuals with Intellectual Disabilities (ICF/IID) means a care facility which is designed, and functions, to meet the needs of four or more individuals with

developmental disabilities, or related conditions, who require twenty-four-~~-~~hour active treatment services.

M. Medical Necessity or Medically Necessary is defined in Section 8.076.1.8.

N. Palliative and Supportive Medical Services means those services and/or interventions which are not ~~curative~~curative, but which produce the greatest degree of relief from the symptoms of the Terminal Illness.

O. Room and Board includes a place to live and the amenities that come with that place to live, including but not limited to provision of:

1. Meals and additional nutritional requirements, as prescribed;

2. Performance of personal care services, including assistance with activities of daily living;

3. Provision of social activities;

4. Equipment necessary to safely care for the ~~client~~Client and to transport the ~~client~~Client, as necessary;

5. Administration of medication;

6. Maintenance of the cleanliness of a ~~client~~Client's room; and

7. Supervision and assistance in the use of durable medical equipment and prescribed therapies.

P. Terminally Ill/Terminal Illness means a medical prognosis of life expectancy of nine months or less, should the illness run its normal course.

8.550.2 INITIATION OF HOSPICE

8.550.2.A. Certification

The Hospice Provider must obtain Certification that a ~~client~~Client is Terminally Ill in accordance with the following procedures:

1. For the first Benefit Period of Hospice coverage or re-Election following revocation or discharge from the Hospice benefit, the Hospice Provider must obtain:

a. A written Certification signed by either the Hospice Provider's medical director or the physician member of the Interdisciplinary Team and the ~~client~~Client's attending physician. The written Certification must be obtained and placed in the Client Record within two calendar days after Hospice Services are initiated. The written Certification must include:

i) A statement of the ~~client~~Client's life expectancy including diagnosis of the terminal condition, other health conditions whether related or unrelated to the terminal condition, and current clinically relevant information supporting the diagnoses and prognosis for life expectancy and Terminal Illness;

ii) The approval of the ~~client~~Client's physician(s) for Hospice Services; and

iii) The approval of the Hospice Provider of Hospice Services for the ~~client~~Client.

b. A verbal Certification statement from either Hospice Provider's medical director or the physician member of the Interdisciplinary Team and the ~~client~~Client's attending physician, if written certification cannot be obtained within two calendar days after Hospice Services are initiated. The verbal Certification must be documented, filed in the Client Record, and include the information described at Section 8.550.2.A.1.a.i, ii, and iii. Written Certification documentation must follow and be filed in the Client Record prior to submitting a claim for payment.

2. At the beginning of each subsequent Benefit Period, the Hospice Provider must obtain a written re-Certification prepared by either the attending physician, the Hospice Provider's medical director or the physician member of the Interdisciplinary Team.

8.550.2.B. Election Procedures

1. An Election of Hospice Services continues as long as there is no break in care and the ~~client~~Client remains with the Elected Hospice Provider.

2. If a ~~client~~Client Elects to receive Hospice Services, the ~~client~~Client or ~~client~~Client representative must file an Election statement with the Hospice Provider that must be maintained in the Client's Record and must include:

a. Designation of the Hospice Provider. A ~~client~~Client must choose only one Hospice Provider as the designated Hospice Provider;

b. Acknowledgment that the ~~client~~Client or ~~client~~Client representative has a full understanding of the palliative rather than curative nature of Hospice Services;

c. Designation by the ~~client~~Client or ~~client~~Client representative of the effective date for the Election period. The first day of Hospice Services must be the same or a later date;

d. An acknowledgement that for the duration of the Hospice Services, the ~~client~~Client waives all rights to Medicaid payments for the following services:

i) Hospice Services provided by a Hospice Provider other than the provider designated by the ~~client~~Client (unless provided under arrangements made by the designated Hospice Provider);

ii) Any Medicaid services that are related to the treatment of the terminal condition for which Hospice Services were Elected, or a related condition, or that are equivalent to Hospice Services, except for services that are:

1) Provided by the designated Hospice Provider;

2) Provided by another Hospice Provider under arrangements made by the designated Hospice Provider;

3) Provided by the individual's attending physician if that physician is not an employee of the designated Hospice Provider or receiving compensation from the Hospice Provider for those services; and,

4) Services provided to ~~client~~Clients ages 20 and under.

e. A signature~~-~~, physical or digital, of either the ~~client~~Client or ~~client~~Client ~~representative as~~representative, as allowed by Colorado law.

3. A ~~client~~Client or client representative may revoke the Election of Hospice Services by filing a signed statement of revocation with the Hospice Provider. The statement must include the effective date of the revocation. The ~~client~~Client must not designate an effective date earlier than the date that the revocation is made. Revocation of the Election of Hospice Services ends the current Hospice Benefit Period.

a. Clients who are dually eligible for Medicare and Medicaid must revoke the Election of Hospice Services under both programs.

4. The ~~client~~Client may resume coverage of the waived benefits as described at 8.550.2.B.2.d. upon revoking the Election of Hospice Services.

5. The ~~client~~Client may re-Elect to receive Hospice Services at any time after the services are discontinued due to discharge, revocation, or loss of Medicaid eligibility, should the ~~client~~Client thereafter become eligible.

6. The ~~client~~Client may change the designation of the Hospice Provider once each Benefit Period. A change in designation of Hospice Provider is not a revocation of the ~~client~~Client's Hospice Election. To change the designation of the Hospice Provider, the ~~client~~Client must file a statement with the current and new provider which includes:

a. The name of the Hospice Provider from which the ~~client~~Client is receiving care and the name of the Hospice Provider from which he or she plans to receive care;

b. The date the change is to be effective; and

c. The signature, physical or digital, of the ~~client~~Client or ~~client~~Client representative~~-~~, as allowed by Colorado law.

8.550.5 ELIGIBLE PLACE OF SERVICE

8.550.5.A. Place of Service

1. Hospice Services are provided in a ~~client~~Client's place of residence, which includes:

a. A residence such as, but not limited to, a house, apartment or other living space that the ~~client~~Client resides within;

b. An assisted living residence including an Alternative Care Facility;

c. A temporary place of residence such as, but not limited to, a relative's home or a hotel. Temporary accommodations may include homeless shelters or other locations provided for a ~~client~~Client who has no permanent residence to receive Hospice Services;

d. Other residential settings such as a group home or foster home;

e. A licensed Hospice Facility or Nursing Facility (NF);

f. An Intermediate Care Facility for ~~the Intellectually~~ Individuals with Intellectual and Developmental Disabilities ~~Disabled~~ (ICF/IID), or Nursing Facility (NF), unless the ~~client~~Client is in a waiver program which does not allow residency in an ICF/IID or NF; or

g. An Individual Residential Services & Supports (IRSS) or a Group Residential Services & Supports (GRSS) host home setting.

2. For Hospice ~~client~~Clients residing in a NF, ICF/IID, IRSS or GRSS, the ~~client~~Client must meet both the Hospice requirements and the requirements for receipt of those Medicaid-covered services.

3. Colorado Medicaid does not reimburse Hospice Services provided in hospitals except when the ~~client~~Client has been admitted for respite services.

8.550.5.B. Hospice Setting Requirements

1. Nursing Facilities:

a. Hospice Services may be provided to a ~~client~~Client who resides in a Medicaid participating NF.

b. When a ~~client~~Client residing in a NF Elects Hospice Services, the ~~client~~Client is considered a Hospice ~~client~~Client and is no longer a NF ~~client~~Client with the exception of the facility's responsibility to provide Room and Board to the ~~client~~Client.

c. In order for a ~~client~~Client to receive Hospice Services while residing in a NF, the Hospice Provider must:

i) Notify the NF that the ~~client~~Client has Elected Hospice and the expected date that Hospice Services will commence;

ii) Ensure the NF concurs with the Hospice plan of care;

iii) Ensure the NF is Medicaid certified; and

iv) Execute a written agreement with the NF, which must include the following:

1) The means through which the NF and the Hospice Provider will communicate with each other and document these communications to ensure that the needs of ~~client~~Clients are addressed and met 24 hours a day;

2) An agreement on the ~~client~~Client's Hospice Service plan of care by the NF staff;

3) A means through which changes in ~~client~~Client status are reported to the Hospice Provider and NF;

4) A provision stating that the Hospice Provider is considered the primary provider and is responsible for any Medically Necessary routine care or continuous care related to the Terminal Illness and related conditions;

5) A provision stating that the Hospice Provider assumes responsibility for determining the appropriate course of Hospice Services, including the determination to change the level of services provided;

6) An agreement that it is the NF provider's responsibility to continue to furnish 24 hour Room and Board care, meeting the personal care, durable medical equipment and nursing needs that would have been provided by the NF at the same level of care provided prior to Hospice Services being Elected;

7) An agreement that it is the Hospice Provider's responsibility to provide services at the same level and to the same extent that those services would be provided if the ~~client~~Client were residing in his or her own residence;

8) A provision that the Hospice Provider may use NF personnel, where permitted by State law and as specified by the agreement, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice Provider would routinely use the services of a ~~client~~Client's family in implementing the plan of care;

9) The NF remains responsible for compliance with mandatory reporting of such violations to the State's protective services agency. As such, the Hospice Provider and its staff or subcontractors must report all alleged violations of a ~~client~~Client's person involving mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of ~~client~~Client property to the NF administrator within 24 hours of the Hospice Provider becoming aware of the alleged violation;

10) Bereavement services that the Hospice Provider will provide to the NF staff;

11) The amount to be paid to the NF or ICF/~~ID~~IID by the Hospice Provider; and

12) An agreement describing whether the Hospice Provider or the NF will be responsible for collecting the ~~client~~Client's patient payment for his or her care.

2. Intermediate Care Facilities for Individuals with Intellectual Disabilities, Independent Residential Support Services, and Group Residential Support Services settings:

a. Hospice Services may be provided to a ~~client~~Client who resides in a Medicaid participating ICF/IID, IRSS or GRSS residential settings. When a ~~client~~Client resides in one of the settings, the ~~client~~Client remains a resident of the ICF/IID, IRSS or GRSS residence. The Hospice Provider must provide services as if treating a ~~client~~Client in his or her place of residence.

b. The Hospice Provider is not responsible for reimbursing the IRSS or GRSS for the ~~client~~Client's Room and Board.

c. In order for a ~~client~~Client to receive Hospice Services while residing in these settings, the Hospice Provider must work with the ICF/IID, IRSS or GRSS to:

i) Notify the ICF/IID, IRSS or GRSS that the ~~client~~Client has Elected Hospice and the expected date that Hospice Services will commence;

ii) Ensure the ICF/IID, IRSS or GRSS concurs with the Hospice plan of care;

iii) Determine the responsibilities covered under the ICF/IID, IRSS or GRSS so that the Hospice Provider does not duplicate service (to include medication and supplies), including:

1) An agreement that the Hospice Provider will be responsible to provide services at the same level and to the same extent as those services would be provided if the ~~client~~Client were residing in his or her private residence; and

2) An agreement of the services the ICF/IID, IRSS or GRSS personnel will perform, where permitted by State law, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice Provider would routinely use the services of a ~~client~~Client's family in implementing the plan of care;

iv) Develop a coordinated plan of care to ensure that the ~~client~~Client's needs are met;

v) Develop a communication plan through which the Hospice Provider and the ICF/IID, IRSS or GRSS will communicate changes in the ~~client~~Client's condition or changes in the ~~client~~Client's care plan to ensure that the ~~client~~Client's needs are met; and

vi) Ensure bereavement services are available to the staff and caregivers of the ~~client~~Client.

3. In settings other than nursing facilities and ICF/IIDs, the Hospice Provider and assisted living residence or foster home must develop an agreement related to the provision of care to the ~~client~~Client, including;

a. Hospice Provider staff access to and communication with staff or caregivers in these facilities or homes;

b. Developing an integrated plan of care;

c. Documenting both respective entities' records, or other means to ensure continuity of communication and easy access to ongoing information;

d. Role of any Hospice vendor in delivering and administering any supplies and medications;

e. Ordering, renewing, delivering and administering medications;

f. Role of the attending physician and process for obtaining and implementing orders;

g. Communicating ~~client~~Client change of condition; and

h. Changes in the ~~client~~Client's needs that necessitate a change in setting or level of care.

8.550.6 ELIGIBLE CLIENTS

8.550.6.A. Requirements

To be eligible to Elect Hospice Services, all of the following requirements must be met:

1. Clients must be Medicaid eligible on the dates of service for which Medicaid-covered Hospice Services are billed. The services must be Medically Necessary, including certification of the ~~client~~Client's Terminal Illness, and appropriate to the ~~client~~Client's needs ~~in order for~~for Hospice Services to be covered by Medicaid.

2. The ~~client~~Client has been certified as being Terminally Ill by an attending physician or the Hospice Provider's medical director.

3. Before services are provided, an initial plan of care must be established by the Hospice Provider in collaboration with the ~~client~~Client and anyone else that the ~~client~~Client wishes to have present for care planning. When the ~~client~~Client is unable to direct his or her own care, care planning must involve the ~~client~~Client's family or caregiver.

4. The ~~client~~Client has agreed to cease any and all curative treatment. Clients ages 20 and younger are exempt from this requirement.

5. Hospice ~~client~~Clients residing in an ICF/IID or NF must meet the Hospice eligibility criteria pursuant to Section 8.550 et. seq., together with functional eligibility, medical eligibility criteria, and the financial eligibility criteria for institutional care as required by Sections 8.400, 8.401, and 8.482.

6. Clients who do not meet eligibility requirements for State Plan Medicaid may be eligible for Medicaid through the long-term care eligibility criteria, which may require the ~~client~~Client to pass a level of care assessment through a designated case management agency.

8.550.6.B. Special Requirements

1. Eligibility for, and access to, Hospice Services does not fall within the purview of the ~~long term~~long-term care Single Entry Point system for prior authorization.

2. Nursing facility placement for a ~~client~~Client who has Medicaid and has Elected Hospice Services in a nursing facility does not require a ~~long term care~~ ULTC 100.2 assessment. The nursing facility must complete a Pre Admission Screening and Resident Review (PASRR).

8.550.8 PROVIDER REQUIREMENTS

8.550.8.D. Provider Responsibilities

1. A Hospice Provider must routinely provide all core services by staff employed by the Hospice Provider. These services must be provided in a manner consistent with acceptable standards of practice. Core services include nursing services, certified nursing aide services, medical social services, and counseling.

2. The Hospice Provider may contract for physician services. The contracted provider(s) will function under the direction of the Hospice Provider's medical director.

3. A Hospice Provider may use contracted staff, if necessary, to supplement Hospice Provider employees in order to meet the needs of the ~~client~~Client. A Hospice Provider may also enter into a written arrangement with another Colorado Medicaid and Medicare certified Hospice program for the provision of core services to supplement Hospice Provider employees/staff to meet the needs of ~~client~~Clients. Circumstances under which a Hospice Provider may enter into a written arrangement for the provision of core services include:

   a. Unanticipated periods of high ~~client~~Client loads, staffing shortages due to illness or other short-term, temporary situations that interrupt ~~client~~Client care;

   b. Temporary travel of a ~~client~~Client outside of the Hospice Provider's service area; and

   c. When a ~~client~~Client resides in a NF, ICF/IID, IRSS or GRSS.

4. The Hospice Provider must ensure, prior to the provision of Medicaid Hospice Services, that ~~client~~Clients are evaluated to determine whether or not they are Medicare eligible. Hospice Services are not covered by Medicaid during the period when a ~~client~~Client is Medicare eligible, except for ~~client~~Clients residing in a NF in which case Medicaid pays to the Hospice Provider an amount for Room and Board.

5. The Hospice Provider must ensure a ~~client~~Client, or his or her legally authorized representative, completes the Hospice Election form prior to or at the time Medicaid Hospice Services are provided.

6. Medicare Hospice Election may not occur retroactively. Therefore, ~~client~~Clients with retroactive Medicare eligibility may receive Medicaid covered services during the retroactive coverage period. The Hospice Provider must make reasonable efforts to determine a ~~client~~Client's status concerning Medicare eligibility or a ~~client~~Client's application for Medicare and must maintain documentation of these efforts. These efforts must include routine and regular inquiry to determine Medicare eligibility for ~~client~~Clients who reach the age of sixty-five and regular inquiry for ~~client~~Clients who indicate they receive ~~Supplemental~~ Social Security Disability Income (SSDI) and are approaching the 24th month of receipt of SSDI. See also Section 8.550.3.

7. Clients who are eligible for Medicare and Medicaid must Elect Hospice Services under both programs.

8. If a ~~client~~Client becomes eligible for Medicaid while receiving Medicare Hospice benefits, Medicare Hospice coverage continues under its current Election period and Medicaid Hospice coverage begins at Medicaid's first Election period.

9. An individual Client Record must be maintained by the designated Hospice Provider and must include:

   a. Documentation of the ~~client~~Client's eligibility for and Election of Hospice Services including the physician certification and recertification of Terminal Illness;

   b. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes;

c. The amount, frequency, and duration of services delivered to the ~~client~~Client based on the ~~client~~Client's plan of care;

d. Documentation to support the care level for which the Hospice Provider has claimed reimbursement; and

e. Medicaid provider orders.

10. Incomplete documentation in the Client Record shall be a basis for recovery of overpayment.

11. Notice of the ~~client~~Client's Election and Benefit Periods must be provided to the Medicaid fiscal agent in such form and manner as prescribed by the Department.

12. The Hospice Provider must provide reports and keep records as the Department determines necessary including records that document the cost of providing care.

13. The Hospice Provider must perform case management for the ~~client~~Client. Medicaid will not reimburse the Hospice Provider separately for this responsibility.

14. The Hospice Provider must designate an Interdisciplinary Team composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the ~~client~~Clients and his or her family facing Terminal Illness and bereavement. Interdisciplinary Team members must provide the care and services offered by the Hospice Provider. The Interdisciplinary Team, in its entirety, must supervise the care and services.

15. The Interdisciplinary Team includes, but is not limited to:

a. A ~~doctor of medicine~~Doctor of Medicine or O~~o~~steopathy, advanced practice nurse, or physician assistant (who is an employee or under contract with the Hospice Provider);

b. A registered nurse or licensed practical nurse;

c. A social worker;

d. A pastoral or other counselor; and

e. The volunteer coordinator or designee.

16. The Hospice Provider must designate a member of the Interdisciplinary Team to provide coordination of care and to ensure continuous assessment of each ~~client~~Client's and family's needs and implementation of the interdisciplinary plan of care. The designated member must oversee coordination of care with other medical providers and agencies providing care to the ~~client~~Client.

17. All Hospice Services and services furnished to ~~client~~Clients and their families must follow an individualized written plan of care established by the Hospice Interdisciplinary Team in collaboration with the ~~client~~Client's primary provider (if any), the ~~client~~Client or his or her representative, and the primary caregiver in accordance with the ~~client~~Client's needs and desires.

18. The plan of care must be established prior to providing Hospice Services and must be based on a medical evaluation and the written assessment of the ~~client~~Client's needs and the needs of the ~~client~~Client's primary caregiver(s).

19. The plan of care must be maintained in the ~~client~~Client's record and must specify:

    a. The ~~client~~Client's medical diagnosis and prognosis;

    b. The medical and health related needs of the ~~client~~Client;

    c. The specific services to be provided to the ~~client~~Client through Hospice and when necessary the NF, ICF/IID, IRSS or GRSS;

    d. The amount, frequency and duration of these services; and

    e. The plan of care review date.

20. The plan of care must be reviewed as needed, but no less frequently than every 15 days. The Interdisciplinary Team leader must document each review. The Interdisciplinary Team members, including the Medicaid provider who is managing the ~~client~~Client's care, must sign the plan of care.

21. The Hospice Provider must ensure that each ~~client~~Client and his or her primary care giver(s) receive education and training provided by the Hospice Provider as appropriate based on the ~~client~~Client's and primary care giver(s)' responsibilities for the care and services identified in the plan of care.

22. The Hospice Provider is responsible for paying for medications, durable medical equipment, and medical supplies needed for the palliation and management of the ~~client~~Client's Terminal Illness.

8.550.9 REIMBURSEMENT

8.550.9.A. Reimbursement Determination

Reimbursement follows the method prescribed in 42 C.F.R. §§ 418.301 through 418.309 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

1. Reimbursement rates are determined by the following:

    a. Rates are published by the Department annually in compliance with the Centers for Medicare and Medicaid Services (CMS) state Medicaid Hospice reimbursement.

    b. Each care-level per-diem rate is subject to a wage index multiplier, to compensate for regional differences in wage costs, plus a fixed non-wage component.

    c. The Hospice wage indices are published annually by October 1 in the Federal Register.

    d. Rates are adjusted for cost-of-living increases and other factors as published by the Centers for Medicare and Medicaid Services.

e. Continuous home care is reimbursed at the applicable hourly rate, the per-diem rate divided by 24 hours, multiplied by the number of hourly units billed from eight up to 24 hours per day of continuous care (from midnight to midnight).

f. Reimbursement for routine home care and continuous home care must be based upon the geographic location at which the service is furnished and not on the business address of the Hospice Provider.

2. Reimbursement for Hospice Services must be made at one of four predetermined care level rates, including the routine home care rate, continuous home care rate, inpatient respite care rate, and general inpatient care rate. If no other level of care is indicated on a given day, it is presumed that routine home care is the applicable rate.

a. Care levels and reimbursement guidelines:

i) The routine home care rate is reimbursed for each day the ~~client~~Client is at home and not receiving continuous home care. This rate is paid without regard to the volume or intensity of Home Care Services provided. This is the service type that must be utilized when a ~~client~~Client resides in a NF, ICF/IID, IRSS or GRSS unless the ~~client~~Client is in a period of crisis.

ii) The continuous home care rate is reimbursed when continuous home care is provided and only during a period of medical crisis to maintain a ~~client~~Client at home. A period of crisis is a period in which a ~~client~~Client requires continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Either a registered nurse or a licensed practical nurse must provide more than half of the billed continuous homecare hours. Homemaker and certified nurse aide services may also be provided to supplement nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate shall be reimbursed up to 24 hours a day. Continuous home care must not be utilized when a ~~client~~Client resides in a NF, ICF/IID, IRSS or GRSS unless the ~~client~~Client is in a period of crisis.

iii) The inpatient respite care rate is paid for each day on which the ~~client~~Client is in an approved inpatient facility for respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. Payment for inpatient respite care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9.B.

iv) The general inpatient rate must be paid only during a period of medical crisis in which a ~~client~~Client requires 24-~~-~~hour continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Payment for general inpatient care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9.B.

3. The Hospice Provider is paid a Room and Board fee in addition to the Hospice per diem for each routine home care day and continuous care day provided to ~~client~~Clients residing in an ICF/IID or NF.

   a. The payment for Room and Board is billed by and reimbursed to the Hospice provider on behalf of the ~~client~~Client residing in the facility. The Department reimburses 95 percent of the facility per diem amount less any patient payments.

   b. Payments for Room and Board are exempt from the computation of the Hospice payment cap.

   c. The Hospice Provider must forward the Room and Board payment to the NF or ICF/IID.

   d. ~~Client~~Clients who are eligible for Post Eligibility Treatment of Income (PETI) shall be eligible for PETI payments while receiving services from a Hospice Provider. The Hospice Provider must submit claims on behalf of the ~~client~~Client and nursing facility or ICF/IID.

   e. Patient payments for Room and Board charges must be collected for Hospice ~~client~~Clients residing in a NF or ICF/IID as required by Section 8.482. While the Medicaid NF and ICF/IID Room and Board payments must be made directly to the Hospice Provider, the patient payment must be collected by the nursing facility or ICF/IID.

   f. Nursing facilities, ICF/IIDs, and Hospice Providers are responsible for coordinating care of the Hospice ~~client~~Client and payment amounts.

4. The Hospice Provider is reimbursed for routine home care or continuous home care provided to ~~client~~Clients residing in a NF or ICF/IID. If a ~~client~~Client is eligible for Medicare and Medicaid and the ~~client~~Client resides in a NF or ICF/IID, Medicare reimburses the Hospice Services, and Medicaid reimburses for Room and Board.

5. Reimbursement for date of discharge:

   a. Reimbursement for date of discharge must be made at the appropriate home care rate for the day of discharge from general or respite inpatient care, unless the ~~client~~Client dies at an inpatient level of care. When the ~~client~~Client dies at an inpatient level of care, the applicable general or respite inpatient rate is paid for the discharge date.

   b. Reimbursement for nursing facility and ICF/IID residents is made for services delivered up to the date of discharge when the ~~client~~Client is discharged, alive or deceased, including applicable per diem payment for the date of discharge.

8.555 COLORADO CHOICE TRANSITIONS (CCT), A MONEY FOLLOWS THE PERSON DEMONSTRATION

8.555.1DEFINITIONS OF DEMONSTRATION SERVICES PROVIDED

Assistive Technology, Extended means devices, items, pieces of equipment, or product system used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.

Caregiver Education means educational and coaching services that assist clients and family members with managing the stress of caregiving and to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.

Community Transition Services means services as defined at 10 CCR 2505-10, Section 8.553.

Dental Services means dental services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health and not available through the Medicaid State Plan.

Enhanced Nursing means medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers.

Home Delivered Meals means nutritious meals delivered to homebound clients who are unable to prepare their own meals and have no outside assistance.

Home Modifications, Extended means physical adaptations to the home, required by the client's plan of care, necessary to ensure the health, welfare, safety and independence of the client above and beyond the cost of caps that exist in applicable Home and Community-Based (HCBS) waivers.

Independent Living Skills Training means services designed to improve or maintain a client's physical, emotional, and economic independence in the community with or without supports.

Intensive Case Management means case management services to assist clients' access to needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition goals.

Peer Mentorship Services means services provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world experiences as example and modeling successful community living and problem-solving.

Transitional Behavioral Health Supports means services by a paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.

Vision Services means services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan.

8.555.2GENERAL DEFINITIONS

Demonstration services means services unique to the CCT program and provided during a client's enrollment in the demonstration program.

Medically complex means one or more medical conditions that are persistent and substantially disabling or life threatening and meets the following conditions:

1.Requires treatment and services across a variety of domains of care;

2.Is associated with conditions that have severe medical or health-related consequences;

3.Affects multiple organ systems;

4.Requires coordination and management by multiple specialties; and

5.Treatments carry a risk of serious complications.

Paraprofessional means a person with a Bachelor's Degree in psychology, social work or other human service related field who is employed by a mental health provider; is supervised by a Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Psychologist; and has experience with facilitating the implementation of a behavioral management plan among families, a client, providers and other members of a support system for the client.

Qualified institution means a nursing facility; intermediate care facilities for people with intellectual disabilities (ICF/ID); or institutions for mental diseases (IMDs), which include Psychiatric Hospitals only to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

Qualified residence means a home owned or leased by the client or the client's family member; a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside; or an apartment with an individual lease, eating, sleeping, cooking and bathing areas, lockable access and egress, and not associated with the provision or delivery of services.

Qualified services mean services that are provided through an existing HCBS waiver and may continue if needed by the client and if the client continues to meet eligibility for HCBS at the end of his or her enrollment in CCT.

Transition Assessment/Plan means an assessment of client needs completed by a transition coordinator prior to a transition and the corresponding plan developed by the coordinator to meet the needs of the client in a community-setting post-transition.

Transition Options Team means a group of individuals who have a personal or professional relationship with the client who is exploring their options for community living. This group is responsible wholly or in part for the transition assessment, transition plan, determining whether the transition is feasible, completing the service plan and brokering services.

8.555.3LEGAL BASIS

The Colorado Choice Transitions (CCT) program is created through a Money Follows the Person (MFP) grant award authorized by section 6071 of the Deficit Reduction Act of 2005. Section 2403 of Patient Protection and Affordable Care Act extended the program through September 30, 2016. The United States Department of Health and Human Services awarded the MFP demonstration grant to Colorado. This demonstration program is administered by the Centers for Medicare and Medicaid Services (CMS). The MFP statute provides waiver authority for four provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of the demonstration. These provisions are:

1. Statewideness (Section 1902(a)(1)) - in order to permit implementation of a State initiative in a selected area or areas of the State.

2. Comparability (Section 1902(a)(10)(B) - in order to permit a State initiative to assist a selected category or categories of individuals enrolled in the demonstration.

3. Income and Resource Eligibility (Section 1902(a)(10)(C)(i)(III) – in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

4. Provider agreement (Section 1902(a)(27)) - in order to permit a State to implement self-direction services in a cost-effective manner for purposes of this demonstration program.

CCT is designed to complement the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD); Home and Community Based Services for People with Brain Injury (HCBS-BI); Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS); Home and Community Based Services for the Developmentally Disabled (HCBS-DD); and Home and Community Based Services for Supported Living Services (HCBS-SLS) programs. These waivers are authorized through Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n).

8.555.4SCOPE AND PURPOSE

8.555.4.A.The CCT program assists clients residing in qualified institutions with exploring their community-based options for long term supports and services; facilitates the transition of clients to a community setting so long as the right services and supports can be arranged in the community to ensure the health, welfare and safety of the client; and provides enhanced services and supports through willing and qualified providers..

8.555.4.B.The CCT program strengthens the transition process for residents of qualified institutions and provides additional supports and services for a successful transition. These additional supports and services are called demonstration services.

8.555.4.C.Clients may be enrolled in the CCT program for 365 days. Days in a hospital or other qualified institution for a period of less than 30 days during the enrollment period will not count towards the 365 days.

8.555.4.D.CCT clients will be concurrently enrolled in the CCT program and one of the following waivers:

1. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) (10. C.C.R. 2505-10, Section 8.485);

2. Home and Community Based Services for People with Brain Injury (HCBS-BI) (10 CCR 2505-10, Section 8.515.00);

3. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) (10 CCR 2505-10, Section 8.509);

4.Home and Community Based Services for the Developmentally Disabled (HCBS-DD) (10 CCR 2505-10, Section 8.500); and

5.Home and Community Based Services for Supported Living Services (HCBS-SLS) (10 CCR 2505-10, Section 8.500.90).

8.555.4.E.At the end of the 365 day enrollment period for the CCT program, case managers will disenroll clients from the program.

1.Demonstration services will terminate at the end of the 365 days of CCT enrollment period.

2.After CCT concludes, if clients continue to meet eligibility requirements for one of the waivers listed in 8.555.4.D.case managers will arrange for the continuation of qualified HCBS services through the appropriate waiver.

8.555.5CLIENT ELIGIBILITY

8.555.5.A.ELIGIBLE PERSONS

CCT services shall be offered only to persons who meet all of the following eligibility requirements:

1.Clients shall be aged 18 years or older.

2.Clients shall have resided in a qualified institution for a period of 90 days. Days in a nursing facility for a rehab stay will not count towards the 90 days.

3.Clients shall be enrolled in Medicaid for at least one day prior to transition from a qualified institution.

4.Clients shall reside in a qualified residence post-transition.

5.Clients shall meet criteria of a targeted population which includes persons with mental illness, brain injury, physical disabilities or intellectual disabilities and the elderly.

6.Clients shall meet the eligibility requirements for the appropriate HCBS waiver programs listed in Section 8.555.4.D. in which they will be enrolled post-transition.

7.Clients concurrently enrolled in the HCBS-BI program and CCT shall be in the age range of 18-64 rather than 16-64 as specified in the HCBS-BI eligibility requirements.

8.555.5.B.FINANCIAL ELIGIBILITY

Clients must meet the financial eligibility requirements specified at 10 CCR 2505-10, Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.555.5.C.LEVEL OF CARE CRITERIA

Clients shall require long term support services at a level comparable to services typically provided in a nursing facility or ICF/D in accordance with the waiver to which they will enroll upon transition.

8.555.5.D.NEED FOR CCT SERVICES

1.Only clients who have agreed to accept demonstration and qualified services as soon as all other eligibility criteria have been met are eligible for the CCT program.

a.Case management shall not be used to satisfy the requirement that a HCBS service must be received within 30 days.

b.The desire or need for any Medicaid services other than CCT demonstration services, as listed at Section 8.555.1, or qualified services offered through one of the waiver programs listed in Section 8.555.4.D. shall not satisfy this eligibility requirement.

2.Once enrolled, clients who have not received demonstration or qualified services for a period greater than 30 consecutive days shall be discontinued from the program.

8.555.5.E.EXCLUSIONS

1.Clients who are residents of nursing facilities, other qualified institutions or hospitals are not eligible to receive CCT or waiver services in preparation for discharge except for but not limited to transition coordination, case management, peer mentorship, independent living skills training, and/or enhanced nursing services.

2.CCT clients readmitted to a qualified institution or hospital may not receive CCT services while admitted except for transition coordination or case management services in preparation for discharge.

a.CCT clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the CCT program but may have the option to re-enroll upon discharge provided they continue to meet all eligibility requirements. The state has the right to exempt the 30 day exclusion on a case-by-case basis.

b.CCT clients entering a nursing facility for Respite Care as a qualified HCBS waiver service shall not be discontinued from the CCT program.

3.Clients who reside in a residence that is not a qualified residence as defined in Section 8.555.2 are not eligible for CCT services.

4.Demonstration services may not be available to clients for certain waivers if those demonstration services are similar to or are the same as services already offered through the state plan or HCBS waiver in which the client will enroll..

8.555.5.F.COST CONTAINMENT AND SERVICE ADEQUACY

1.The client shall not be eligible for the CCT program if:

a.The Department or its agent determines that the client's needs cannot be met within the specific cost containment requirements set for the HCBS waiver in which they will enroll..

b.The transition assessment reveals that the client's needs are more extensive than CCT demonstration services and/or HCBS qualified or state plan services are able to support and/or that the client's health and safety cannot be reasonably assured in a community setting.

2.In the event that the Department or its agent denies or reduces the request for services prior to transition, the case manager shall provide the client with the client's appeal rights pursuant to Section 8.555.12.

3.The client may be eligible for continuation with an HCBS waiver program following the CCT enrollment period if the case manager at reassessment determines that qualified services are able to support the client's needs and the client's health and safety can be assured in a community setting with HCBS services.

a.If the case manager expects that the services required to support the client's needs will exceed the cost containment requirements for the waiver in which the client is enrolled, the Department or its agent will review the service plan to determine if the client's request for services is appropriate and justifiable based on the client's condition.

i)The client may request of the case manager that existing qualified services remain intact during this review process. CCT demonstration services will still end on the 365th day of the client's enrollment in the CCT program.

ii)In the event that the request for services is denied by the Department or its agent, the case manager shall provide the client with:

1)The client's appeal rights pursuant to Section 8.555.12; and

2)Alternative options to meet the client's needs that may include, but are not limited to, nursing facility or ICF/ID placement.

8.555.6CCT ENROLLMENT

8.555.6.A.Clients and legal guardians, if appointed, shall demonstrate by signature that he or she provides consent to participate in the CCT demonstration program; understands the roles and responsibilities of the client, case manager and transition coordinator; and agrees to participate in the program evaluation activities. If there is a dispute between the client and the guardian regarding participation in the CCT program, the dispute shall be resolved in accordance with guardianship statutes and regulations.

8.555.6.BTransition coordinators and case managers will ensure that clients meet all eligibility requirements identified in Section 8.555.5 prior to enrollment.

8.555.6.C.Transition coordinators shall facilitate the completion of the Department approved Transition Assessment/Plan for each client with the support of the transitions options team members.

8.555.6.D.Transition coordinators and case managers will follow all policies and procedures defined by the state and made available through trainings and other guidance.

8.555.6.E.Transition coordinators shall act in accordance with Department guidance and the requirements established in 10 C.C.R. 2505-10, Section 8.553.

8.555.7START DATE FOR SERVICES

8.555.7.A.The start date of eligibility for CCT services shall not precede the date that all of the requirements at Section 8.555.5 have been met.

8.555.7.B.The first date for which CCT services may be reimbursed shall be the date of discharge from a qualified institution.

8.555.7.C.Transition coordination services and case management services may be offered prior to the client's transition in preparation of the transition to a community setting. Other services may be provided pre-transition with Departmental approval if the service is necessary for transition. Services shall be billed retroactively upon the date of discharge or up to 120 days after discharge.

8.555.8CASE MANAGEMENT FUNCTIONS

8.555.8.A.The requirements at 10 CCR 2505-10, Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the CCT program and the HCBS-EBD, HCBS-CMHS or HCBS-BI waiver programs. Case managers for these waivers shall comply with these requirements and the CCT-specific requirements in the rest of this section.

8.555.8.B.The requirements at 10 CCR 2505-10, Section 8.760 shall apply to the Case Management Agencies performing the case management functions of the CCT program and the HCBS-SLS or HCBS-DD programs. Case managers for these waivers shall comply with these requirements and the CCT-specific requirements in the rest of this section.

8.555.8.C.The case manager is responsible for:

1.Assessing needs;

2.Determining CCT and waiver program eligibility;

3.Service planning and authorization;

4.Arranging services;

5.Identifying potential risks for reinstitutionalization;

6.Implementing strategies with the client and family to mitigate risks;

7.Monitoring services;

8.Monitoring the health, welfare and safety of the client; and

9.Promotion of client's self-advocacy.

8.555.8.D.The case manager shall administer the first Quality of Life (QoL) Survey (baseline survey) within 14 days prior to the participant's transition to community living. For surveys conducted at 11 and 24 months following transition, the Department will send a survey request to the case management agencies (CMA) in the area where the survey needs to be completed. Once assigned, the interviewer from a CMA will schedule a time with the client and/or his or her proxy in the month that the survey is due and submit results to the Department.

8.555.8.E.The case manager shall conduct a home visit with the transition coordinator on the date of discharge to::

1.Confirm the start of services;

2.Ensure clients are safe; and

3.Identify and address any unanticipated concerns, issues and problems clients may have with the transition.

8.555.8.F.The case manager shall conduct a check-in with the client by phone 48 hours after discharge and conduct any necessary follow-up activities needed.

8.555.8.G.The case manager shall conduct three additional home visits in the first month that clients are enrolled in the program to provide support for success with community living.

8.555.8.H.The case manager shall tailor the frequency of contacts to the individual needs of the clients. Regular contacts, with clients, family members, guardians or other designated representatives for the duration of their enrollment in the CCT program to monitor services and the health, welfare and safety of the clients; and to conduct any necessary follow-up activities necessary to ensure independent living in the community is expected. The Department prefers that within the first few months post-transition that the case manager shall have a minimum of weekly contacts.

Contacts may either be phone contacts or home visits based on necessity.

8.555.8.I.The case manager shall revise the service plan, risk mitigation plan, and emergency back-up plan as needed based on the weekly contacts or as otherwise needed due to change in the client's condition.

8.555.8.J.The case manager shall review the client's most recent ULTC 100.2 and update the ULTC 100.2 assessment if a change in functional status or a significant change impacting eligibility has occurred, in accordance with 10 CCR 2505-10, Section 8.401.1.

8.555.8.K.The case manager shall begin preparing clients for dis-enrollment from the CCT program 90 days prior to the end of the clients' CCT enrollment period and arrange for the continuation of HCBS services if the clients continue to meet the eligibility requirements for a waiver listed at 8.555.4.D.

8.555.9SERVICE PLAN

8.555.9.A.The service plan will be developed with input from the transition coordinator, staff from the discharging facility, the resident wanting to transition and others at the invitation of the client or guardian.

8.555.9.B.The transition assessment/plan, the client's level of functioning, service needs, available resources and potential funding resources will inform the development of the service plan.

8.555.9.C.The service plan shall:

1.Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver qualified services, CCT demonstration services or through other means;

2.Identify risks to reinstitutionalization and outline a contingency plan identifying paid and unpaid supports and services necessary to mitigate the risk.

3.Be in accordance with the rules, policies and procedures related to service plans established by the Division for Developmental Disabilities if clients are enrolled in the HCBS-SLS (10 CCR 2505-10, Section 8.500.95) or -DD waivers (10 CCR 2505-10, Section 8.500.6);

4.Be in accordance with the rules, policies and procedures established related to service plans by the Department of Health Policy and Financing for clients enrolled in the HCBS-EBD (10

~~CCR 2505-10, Section 8.486.51), -CMHS (10 CCR 2505-10, Section 8.509.31.D.) or -BI waivers (10 CCR 2505-10, Section 8.516.30.);~~

~~5.Include updates and revisions when warranted by changes in the client's needs or conditions.~~

~~8.555.9.D.The service plan shall document that the client has been offered a choice:~~

~~1.Between community-based services or institutional care;~~

~~2.Between the CCT Program or a traditional HCBS Waiver;~~

~~3.Among qualified and demonstration services; and~~

~~4.Among qualified providers.~~

~~8.555.9.E.A new service plan will be developed each time a client is reinstitutionalized and plans to return to a community setting. The service plan shall address the reasons for the client's reinstitutionalization.~~

~~8.555.10PROVIDER REIMBURSEMENT~~

~~8.555.10.A.All CCT demonstration and qualified services must be prior authorized by the Department or its agent.~~

~~8.555.10.B.The Department shall develop the Prior Authorization Request (PAR) form to be completed by case managers who shall comply with all applicable regulations when completing the form.~~

~~8.555.10.C.The Department or its agent shall determine if the services requested are:~~

~~1.Consistent with the client's documented medical condition and functional capacity;~~

~~2.Reasonable in amount, scope, frequency, and duration;~~

~~3.Not duplicative of the other services included in the client's service plan;~~

~~4.Not for services for which the client is receiving funds to purchase; and~~

~~5.Do not total more than 24 hours per day of care.~~

~~8.555.10.D.The services requested on the PAR must meet all criteria listed at 8.555.10.C for the Department or its agent to approve the request.~~

~~8.555.10.E.If the Department or its agent determines that the services requested on the PAR do not meet the criteria at 8.555.10.C., the Department or its agent shall deny the PAR and work with the case management agency to submit a revised request.~~

~~1.If services are reduced or denied through a revised PAR, the case manager shall provide the client with the client's appeal rights pursuant to Section 8.555.12.~~

~~8.555.10.F.The prior authorization of services does not constitute an entitlement to those services, and does not guarantee payment.~~

~~8.555.10.G.The PAR start date shall not precede the start date of CCT eligibility in accordance with Section 8.555.7.~~

8.555.10.H.The PAR end date shall not exceed the end date of the initial CCT enrollment period, which cannot exceed 365 calendar days.

8.555.10.I.Revisions to the PAR that are requested six months or more after the end date of CCT enrollment shall be disapproved.

8.555.10.J.Prior to the end date, case managers shall establish a new CCT enrollment period and create a new PAR to reflect any days during the initial enrollment period that a client entered a hospital, nursing home, ICF/ID or other long- care institution for a period less than 30 days to ensure the client has a full 365 days of CCT enrollment in the community.

1.The numbers of days for the new enrollment period and PAR shall be equal to the numbers of days that the client was placed in an institution and shall commence on the first day after the end date of the initial enrollment period.

8.555.10.K.Prior Authorization Requests for clients enrolled in the HCBS-DD waiver shall be completed in accordance with Section 8.500.12

8.555.10.L.Prior Authorization Requests for clients enrolled in the HCBS-SLS waiver shall be completed in accordance with Section 8.500.101.

8.555.10.M.The PAR for qualified and demonstration services shall be sent to the Department or its agent for approval.

8.555.10.N.Approval of the PAR by the Department shall authorize providers of CCT services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. However, a PAR does not guarantee payment.

8.555.10.O.Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

8.555.10.P.Payment for CCT Services

1.Payment for CCT services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.

a.Rates for, Caregiver Education, Community Transition Services, Enhanced Nursing,, Home Delivered Meals, Extended, Independent Living Skills Training, Intensive Case Management, Peer Mentorship Service, , and Transitional Behavioral Health Supports are reimbursed on a fee-for-service basis and payment is based on the rate for each service found on the Departments statewide fee schedule.

b.The statewide fee schedule for these services are reviewed annually and published in the provider billing manual.

c.Payment for the following services is reimbursed at billed cost but cannot exceed the Department's established maximums: Assistive Technology, Extended, Dental Services, Home Modifications, Extended, and Vision services..

2.Payment for CCT services is also conditional upon:

a.The client's eligibility for CCT services;

b.The provider's certification status; and

c.The submission of claims in accordance with proper billing procedures.

8.555.11PROVIDER AGENCIES

8.555.11.A.CCT providers providing demonstration services to clients enrolled in CCT and HCBS-EBD, -BI, or -CMHS shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.487.

8.555.11.B.CCT providers providing demonstration services to clients enrolled in CCT and HCBS-DD shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.500.9.

8.555.11.C.CCT providers providing demonstration services to clients enrolled in CCT and HCBS-SLS shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.500.98.

8.555.11.D.CCT providers of specific demonstration services must:

1.Conform to all state established standards for the specific services they provide under this program.

2.Abide by all the terms of their provider agreement with the Department; and

3.Comply with all applicable federal and state statutes, regulations and guidance

4.A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services

8.555.12APPEAL RIGHTS

8.555.12.A.Case management agencies shall follow the rules for notification and appeals established for the waiver in which the client will enroll upon discharge.

1.For clients enrolled on HCBS-EBD, -BI and -CMHS, the case management agencies or utilization review contractor shall provide notification of adverse actions and appeals rights in accordance with 8.393.28.A.

2.For clients enrolled on HCBS-DD, the case management agencies shall provide notification of adverse actions and appeal rights in accordance with 8.500.16.

3.For clients enrolled on HCBS-SLS, the case management agencies shall provide notification of adverse actions and appeal rights in accordance with 8.500.106.

8.600 Services for Individuals with Intellectual and Developmental Disabilities

8.600.1 Authority

A. These rules are promulgated under the authorities established in ~~s~~Section 25.5-10, C.R.S.

B. These rules and the program guidelines, standards and policies of the Colorado Department of Health Care Policy and Financing, These rules and the program guidelines, standards and policies of the Colorado Department of Health Care Policy and Financing, ~~Division for Intellectual and Developmental Disabilities,~~ shall apply to all community centered boards, service agencies and regional centers receiving funds administered by the Colorado Department of Health Care Policy and Financing.

8.600.2 Scope and Purpose

These rules govern services and supports for individuals with developmental disabilities authorized and funded in whole or in part through the Colorado Department of Health Care Policy and Financing. These services and supports include the following, as provided by the Colorado Revised Statutes and through annual appropriation authorizations by the Colorado General Assembly:

A. Services and supports provided to residents of a State operated facility or program or purchased by the Department.

B. The purchase of services and supports through Community Centered Boards, case management agencies, and service agencies.

C. Other services and supports specifically authorized by the Colorado General Assembly.

D. Services and supports funded through the Home and Community-Based Services waivers under Sections 1915(c), 1902(a)(10), and 1902(a)(1) of the Social Security Act and under Section 25.5-4-401, et seq., C.R.S.

8.600.3 Consequences for Non-Compliance

A. Pursuant to ~~section~~Title 25.5, Article -10, C.R.S., upon a determination by the Executive Director or designee that services and supports have not been provided in accordance with the program or financial administration standards contained in these rules, the Executive Director or designee may reduce, suspend, or withhold payment to a community centered board, service agency under contract with a community centered board, or service agency from which the Department purchases services or supports directly.

B. Prior to initiating action to reduce, suspend, or withhold payment to a community centered board or service agency for failure to comply with rules and regulations of the Department, the Executive Director or designee shall specify the reasons therefor in writing and shall specify the actions necessary to achieve compliance.

C. The Executive Director or designee may revoke the designation of a community centered board upon a finding that the community centered board is in violation of provisions of ~~s~~Section 25.5-10, C.R.S., other state or federal laws, or these rules.

8.600.4 Definitions

As used in these rules, unless the context requires otherwise:

"Abuse is as defined at Sections 16-22-102 (9), 19-1-103, 25.5-10-202 (1) (a)-(c), and 26.3.1-101 C.R.S.,~~" for the purpose of mistreatment, abuse, neglect and exploitation, means any of the following acts or omissions committed against a person with an intellectual or developmental disability:~~

~~A. The non-accidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;~~

~~B. Confinement or restraint that is unreasonable under generally accepted caretaking standards; or~~

~~C. The subjection to sexual conduct or contact classified as a crime under the "Colorado Criminal Code," Title 18, C.R.S.~~

"Algorithm" means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Clients into one of six support levels in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.

"Assistive Technology Devices" means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

"Assistive Technology Services" includes, but is not limited to, the evaluation of a person's need for assistive technology; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and, training the individual, or if appropriate a family member, to use the devices effectively.

Authorized Representative means an individual designated by a Client or by the parent or guardian of the Client, if appropriate, to assist the Client in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined in 8.510.1.

"Authorized Services" means those services and supports authorized pursuant to Section 25.5-10-206, C.R.S., which the Department shall provide directly or purchase subject to available appropriations for persons who have been determined to be eligible for such services and supports and as specified in the eligible person's individualized plan.

"Caretaker" is as defined at Section 25.5-10-202(1.6)(a)-(c), C.R.S. ~~means a person who:~~

~~A. Is responsible for the care of a person with an intellectual or developmental disability as a result of a family or legal relationship;~~

~~B. Has assumed responsibility for the care of a person with an intellectual or developmental disability; or~~

~~C. Is paid to provide care, services, or oversight of services to a person with an intellectual or developmental disability~~.

"Caretaker Neglect" is as defined at Section 25.5-10-202(1.8)(a)-(c), C.R.S. ~~means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health and safety of a person with an intellectual and developmental disability is not secured for a person with an intellectual and developmental disability or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult with an intellectual and developmental disability.~~

~~A.Notwithstanding the provisions of this subsection, the withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation, dialysis, artificial nutrition and hydration, in accordance with any~~

~~valid medical directive or order, or as described in a palliative plan of care, shall not be deemed caretaker neglect.~~

~~B. As used in this subsection, "medical directive or order" includes a medical durable power of attorney, a declaration as to medical treatment executed pursuant to Section 15-18-108, C.R.S., a medical order for scope of treatment form executed pursuant to Article 18.7 of Title 15, C.R.S., and a CPR Directive executed pursuant to Article 18.6 of Title 15, C.R.S.~~

"Case Management Agency" (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

"Challenging Behavior" means behavior that puts the person at risk of exclusion from typical community settings, community services and supports, or presents a risk to the health and safety of the person or others or a significant risk to property.

"Client" means an individual who has met Long-Term Services and Supports (LTSS) eligibility requirements and has been offered and agreed to receive Home and Community Based Services (HCBS) in the Children's Extensive Supports (HCBS-CES) waiver, the HCBS waiver for Children's Habilitation Residential Program (CHRP), the HCBS waiver for Persons with Developmental Disabilities (HCBS-DD), Family Support Services Program (FSSP),or the Supported Living Services (HCBS-SLS) waiver.

"Community Centered Board" means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

"Comprehensive Review of the Person's Life Situation" means a thorough review of all aspects of the person's current life situation by the program approved service agency in conjunction with other members of the interdisciplinary team.

"Comprehensive Services" means habilitation services and supports that provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services include residential habilitation services and supports, day habilitation services and supports and transportation.

"Consent" means an informed assent, which is expressed in writing and is freely given. Consent shall always be preceded by the following:

A. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

B. A description of the attendant discomforts and risks;

C. A description of the benefits to be expected;

D. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

E. An offer to answer any inquiries regarding the procedure;

F. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

G. A statement that withholding or withdrawal of consent shall not prejudice future provision of appropriate services and supports to individuals.

"Developmental Delay" means that a child meets one or more of the following:

A. A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more of the following:

1. Chromosomal conditions associated with delays in development,

2. Congenital syndromes and conditions associated with delays in development,

3. Sensory impairments associated with delays in development,

4. Metabolic disorders associated with delays in development,

5. Prenatal and perinatal infections and significant medical problems associated with delays in development,

6. Low birth weight infants weighing less than 1200 grams, or

7. Postnatal acquired problems resulting in delays in development.

B. A child less than five (5) years of age who is significantly delayed in development in one or more of the following areas:

1. Communication,

2. Adaptive behavior,

3. Social-emotional,

4. Motor,

5. Sensory, or

6. Cognition.

C. A child less than three (3) years of age who lives with one or both parents who have a developmental disability.

"Critical Incident" means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to: Injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death

"Developmental Disabilities Professional" means a person who has at least a Bachelor's Degree and a minimum of two (2) years' experience in the field of developmental disabilities or a person with at least five (5) years of experience in the field of developmental disabilities with competency in the following areas:

A. Understanding of civil, legal and human rights;

B. Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies;

C. Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.

"Developmental Disability" means a disability that:

A. Is manifested before the person reaches twenty-two (22) years of age;

B. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria below at C, 1 and/or C, 2; and,

C. Is attributable to an intellectual and developmental disability or related conditions which include Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found 42 U.S.C. § 15002, et seq., shall not apply.

1. "Impairment of general intellectual functioning" means that the person has been determined to have a full scale intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15).

a. A secondary score comparable to the General Abilities Index for a Wechsler Intelligence Scale that is two or more standard deviations below the mean may be used only if a full scale score cannot be appropriately derived.

b. Score shall be determined using a norm-referenced, standardized test of general intellectual functioning comparable to a comprehensively administered Wechsler Intelligence Scale or Stanford-Binet Intelligence Scales, as revised or current to the date of administration. The test shall be administered by a licensed psychologist or a school psychologist.

c. When determining the intellectual quotient equivalent score, a maximum confidence level of ninety percent (90%) shall be applied to the full scale score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the applicant being determined to have a developmental disability.

2. "Adaptive behavior similar to that of a person with intellectual disability " means that the person has an overall adaptive behavior composite or equivalent score that is two or more standard deviations below the mean.

a. Measurements shall be determined using a norm-referenced, standardized assessment of adaptive behaviors that is appropriate to the person's living environment and comparable to a comprehensively administered Vineland Scale of Adaptive Behavior, as revised or current to the date of administration. The assessment shall be administered and

determined by a professional qualified to administer the assessment used.

b. When determining the overall adaptive behavior score, a maximum confidence level of ninety percent (90%) shall be applied to the overall adaptive behavior score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the applicant being determined to have a developmental disability.

D. A person shall not be determined to have a developmental disability if it can be demonstrated such conditions are attributable to only a physical or sensory impairment or a mental illness.

~~"Division for Intellectual and Developmental Disabilities" means the unit within the Colorado Department of Health Care Policy and Financing, responsible for the administration of state sponsored services and funding for developmental disabilities for the state of Colorado.~~

"Emergency", as used in Section 8.608.3 regarding restraint, means a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm.

"Emergency Control Procedure" means an unanticipated use of a restrictive procedure or restraint in order to keep the person receiving services and others safe.

"Executive Director" means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

"Exploitation" is as defined in Section 25.5-10-202(15.5)(a)-(d) and 26-3.1-101 C.R.S. ~~means an act or omission committed by a person who:~~

~~A. Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person with an intellectual or developmental disability of the use, benefit, or possession of anything of value;~~

~~B. Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person with an intellectual or developmental disability; or~~

~~C. Forces, compels, coerces, or entices a person with an intellectual or developmental disability to perform services for the profit or advantage of the person or another person against the will of the person with an intellectual or developmental disability; or~~

~~D. Misuses the property of a person with an intellectual or developmental disability in a manner that adversely affects the person with an intellectual or developmental disability's ability to receive health care or health care benefits or to pay bills for basic needs or obligations.~~

"Extreme Safety Risk to Self" means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client:

A. Displays self-destructiveness related to self-injury, suicide attempts or other similar behaviors that seriously threaten the Client's safety; and,

B. Has a rights suspension in accordance with Section 8.604.3 or has a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits the ability of the Client to harm himself or herself.

“Family”, as used in rules pertaining to support services and the Family Support Services Program means a group of interdependent persons residing in the same household that consists of a family member with a developmental disability or a child under the age of five (5) years with a developmental delay, and one or more of the following:

A. A mother, father, brother(s), sister(s) or any combination; or,

B. Extended blood relatives such as grandparent(s), aunt(s) or uncle(s); or,

C. An adoptive parent(s); or,

D. One or more persons to whom legal custody of a person with a developmental disability has been given by a court; or,

E. A spouse and/or his/her children.

“Family Support Council” means the local group of persons within the Community Centered Board's designated service area who have the responsibility for providing guidance and direction to the Community Centered Board for the implementation of the Family Support Services Program.

“Family Support Plan (FSP)” means a plan which is written for the delivery of family support services as specified in Section 8.613.

“Functional Analysis” means a comprehensive analysis of the medical, social, environmental, and personal factors that may influence current behavior. This analysis shall also investigate the person's ability to communicate, analyze whether the current behavior is a means to communicate, and identify historical factors which may contribute to the understanding of the current behavior.

“Guardian” means a person who has qualified as a guardian of a minor or incapacitated person ~~pursuant to~~by testamentary or count appointment but excludes a Guardian Ad Litem ~~(C.R.S. 15-10-201)~~.

“Harmful Act” is as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.

“Home and Community-Based Services Waivers (HCBS)” means HCBS waiver programs, including the Home and Community Based Waiver for the Developmentally Disabled (HCBS-DD), Supported Living Services (SLS) and Children's Extensive Support (CES). “Host Home Provider” is an individual(s)who provides residential supports in his/her home to persons receiving comprehensive services who are not family members as defined in Section 25.5-10-202(16), C.R.S. A host home provider is not a developmental disabilities service agency pursuant to Section 8.602 of these rules.

“Human Rights Committee” means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and reviewing investigations of allegations of mistreatment of persons with intellectual and developmental disabilities who are receiving services or supports.

“Individual Service and Support Plan (ISSP)” means a plan of intervention or instruction which directly addresses the needs identified in the person's Individualized Plan and which provides specific direction and methodology to employees and contractors providing direct service to a person.

“Individualized Plan (IP)” means a written plan designed by an interdisciplinary team for the purpose of identifying:

A. The needs of the person receiving services or family;

B. The specific services and supports appropriate to meet those needs;

C. The projected date for initiation of service and supports; and,

D. The anticipated results to be achieved by receiving the services and supports.

“Interdisciplinary Team (IDT)” means a group of people convened by a Community Centered Board which shall include the person receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by such person's needs and preferences, who are assembled in a cooperative manner to develop or review the individualized plan.

“Mechanical Restraint” means the use of devices intended to restrict the movement or normal functioning of a portion of an individual's body. Mechanical restraint does not include the use of protective devices used for the purpose of providing physical support or prevention of accidental injury.

“Minimum Effective Dose” means the smallest medication dosage necessary to produce the intended effect.

“Mistreated” or “Mistreatment” is as defined at Sections 25.5-10-202(29.5)(a)-(d) and 26-3.1-101 C.R.S.~~means~~:

~~A. Abuse,~~

~~B. Caretaker Neglect,~~

~~C. Exploitation,~~

~~D. An act or omission that threatens the health, safety, or welfare of a person with intellectual or developmental disability, or~~

~~E. An act or omission that exposes the person with an intellectual or developmental disability to a situation or condition that poses an imminent risk of bodily injury~~.

“Notice” means written notification hand delivered to or sent by first class mail that contains at least all of the following:

A. The proposed action;

B. The reason or reasons for that action;

C. The effective date of that action;

D. The specific law, regulation, or policy supporting the action;

E. The responsible agency with whom a protest of the action may be filed including the name and address of the director.

F. The dispute resolution procedure, including deadlines, in conformity with Section 8.605 and procedures on accessing agency records:

1. For disputes involving individuals as defined in Section 8.605.2, information on availability of advocacy assistance, including referral to publicly funded legal

services, corporation, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under 42 U.S.C. 15001, the Developmental Disabilities Assistance and Bill of Rights Act; and,

2. For disputes involving individuals as defined in Section 8.605.2 an explanation of how the agency will provide services to a currently enrolled person during the dispute resolution period, including a statement that services will not be terminated during the appeal. Such explanation will include a description of services currently received.

“Parent” means the biological or adoptive parent.

“Physical Restraint” means the use of manual methods to restrict the movement or normal functioning of a portion of an individual's body through direct physical contact by others except for the purpose of providing assistance/prompts. Assistance/prompts is the use of manual methods to guide or assist with the initiation or completion of and/or support the voluntary movement or functioning of an individual's body through the use of physical contact by others except for the purpose of providing physical restraint.

“PRN” (Pro Re Nata) means giving drugs on an “as needed” basis through a standing prescription or standing order.

“Program Approved Service Agency” means a developmental disabilities service agency or typical community service agency as defined in Section 8.602, which has received program approval by the Department pursuant to Section 8.603 of these rules.

“Program Services” means an organized program of therapeutic, habilitative, specialized support or remedial services provided on a scheduled basis to individuals with developmental disabilities.

“Prospective New Service Agency” means an individual or any publicly or privately operated program, organization or business that has completed and submitted an application with a Community Centered Board for selection and approval as a service agency to provide comprehensive services.

“Public Safety Risk-Convicted” means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

A. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,

B. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

“Public Safety Risk-Not Convicted” means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

A. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,

B. A rights suspension in accordance with Section 8.604.3or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled

environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

"Rate" means the amount of money, determined by a standardized rate setting methodology, reimbursed for each unit of a defined waiver service provided to a Client by a qualified provider.

"Referral" means any notice or information (written, verbal, or otherwise) presented to a Community Centered Board which indicates that a person may be appropriate for services or supports provided through the developmental disabilities system and for which the Community Centered Board determines that some type of follow-up activity for eligibility is warranted.

~~"Referral and Placement Committee (RPC)" means an interdisciplinary or interagency committee authorized by a Community Centered Board or the department to make referral and placement recommendations for persons receiving services.~~

"Request for Provider (RFP)" means a formal process for case managers to notify Program Approved Provider Agencies when a Client is seeking authorized services~~, to include~~including, but not limited to, a non-identifying description of the client's support and supervision needs.

"Regional Center" means a facility or program operated directly by the Department of Human Services, which provides services and supports to persons with developmental disabilities.

"Respondent" means a person participating in the SIS assessment who has known the Client for at least three months and has knowledge of the Client's skills and abilities. The respondent must have recently observed the Client directly in one or more places such as home, work, or in the community.

"Restrictive Procedure" means any of the following when the intent or plan is to bring an individual's behavior into compliance:

A. Limitations of an individual's movement or activity against his or her wishes; or,

B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences.

"Request for Developmental Disability Determination" means written formal documentation, either handwritten or a signed standardized form, which is submitted to a Community Centered Board requesting that a determination of developmental disability be completed.

"Safety Control Procedure" means a restrictive procedure or restraint that is used to control a previously exhibited behavior which is anticipated to occur again and for which the planned method of intervention is developed in order to keep the person and others safe.

"Screening for Early Intervention Services" means a preliminary review of how a child is developing and learning in comparison to other similarly situated children. "Seclusion" means the placement of a Client alone in a closed room for the purpose of punishment. Seclusion for any purpose is prohibited.

"Service Agency" means an individual or any publicly or privately operated program, organization or business providing services or supports for persons with developmental disabilities.

~~"Sexual contact" means the intentional touching of the victim's intimate parts by the actor, or of the actor's intimate parts by the victim, or the intentional touching of the clothing covering the immediate area of the victim's or actor's intimate parts if that sexual contact is for the purposes of sexual arousal, gratification, or abuse.~~

~~"Sexual intrusion" means any intrusion, however slight, by any object or any part of a person's body, except the mouth, tongue, or penis, into the genital or anal opening of another person's body if that sexual intrusion can reasonably be construed as being for the purposes of sexual arousal, gratification, or abuse.~~

~~"Sexual penetration" means sexual intercourse, cunnilingus, fellatio, analingus, or anal intercourse. Emission need not be proved as an element of any sexual penetration. Any penetration, however slight, is sufficient to meet this definition..~~

“SIS Interviewer” means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department approved trainer using the Department approved curriculum. SIS Interviewers must maintain a standard for conducting SIS assessments as measured through periodic interviewer reliability reviews.

“Statewide Database” means the state web-based system that contains consumer-related demographic and program data.

“Support Coordinating Agency” means a Community Centered Board which has been designated as the agency responsible for the coordination of support services (supported living services for adults and the children's extensive support program) within its service area.

“Supports Intensity Scale” (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

“Support Level” means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

“Undue Influence” means use of influence to take advantage of a person with an intellectual or developmental disability’s vulnerable state of mind, neediness, pain, or emotional distress.

“Waiver Services” means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid State Plan services.

8.600.5 OTHER PROVISIONS

A. All regional centers, community centered boards, and program approved service agencies shall maintain copies of statutes and rules and regulations relevant to the provision of authorized services, and shall ensure that appropriate employees and contractors have access to such copies and are oriented to the content of the statutes and rules.

B. All regional centers, community centered boards, and program approved service agencies shall have written policies and procedures concerning the exercise and protection of individual rights pursuant to ~~section~~ Title 25.5, Article ~~-~~10, C.R.S.

C. All regional centers, community centered boards, and program approved service agencies shall have written procedures for the protest of agency decisions or actions of the agency's employees or contractors by the person receiving services or parent of a minor or guardian of such person, or authorized representative if within the scope of his/her duties, which procedures shall meet requirements of S~~s~~ection 8.605 of these rules. Interpretation in native languages other than English and through such modes of communication as may be necessary shall be made available upon request.

D. Community centered boards shall serve as the single point of entry into authorized services funded by the State of Colorado, Department of Health Care Policy and Financing, both in community settings and regional centers.

E. Persons with developmental disabilities will be considered for referral, enrollment or discharge from authorized services, funded in whole or in part by the State of Colorado, without discrimination on the basis of race, religious or political affiliation, gender, national origin, age or disability.

F. All regional centers, community centered boards, and service agencies shall provide information and reports as required by the Department including, but not limited to, data necessary for the Department's data system, COPAR, billing records, and legislative reports

G. A waiver of the specific requirements of these rules and regulations may be granted for a specifically stated duration by the Department in accordance with this section:

1. A waiver of these rules and regulations may be granted only upon a finding that the waiver would not adversely affect the health, safety, welfare or rights and privileges of persons with developmental disabilities and upon further finding that a valid programmatic reason exists or a demonstrated financial hardship on the community centered board or service agency seeking the waiver such that the provision of necessary services and supports to persons served would be endangered.

2. The Department shall not waive any requirement of these rules and regulations that would in any way jeopardize the receipt of federal financial participation or other funding necessary for the provision of services and supports to persons with developmental disabilities, nor shall the Department approve waivers of rules and regulations that would in any way materially affect the rights and privileges of individuals with developmental disabilities as provided by the Colorado Revised Statutes and other applicable state and federal laws and regulations.

3. No waiver granted by the Department shall in any way constitute a waiver of the obligations of the community centered board or service agency under rules and regulations of other departments and agencies of the State of Colorado or the federal government.

4. The community centered board, service agency or regional center seeking a waiver of any of the rules and regulations contained herein bears the burden of proof in demonstrating that the waiver sought is in conformity with these provisions.

H. The community centered board, service agency, and regional center shall allow access by authorized personnel of the Department, or designee, for the purpose of reviewing services and supports which are funded by the Department and shall cooperate with the Department in the evaluation of such services and supports.

~~**8.600.6EVALUATIONS TO DETERMINE IF A DEFENDANT IS MENTALLY RETARDED**~~

~~A.The Executive Director or his/her designee shall convene a panel of not fewer than three (3) individuals with expertise in mental retardation, one of whom shall be the person responsible for the state administration of community services to persons with a developmental disability or his/her designee.~~

~~B.The panel shall determine a process to screen psychologists in order to unanimously recommend specific psychologists to the Executive Director in sufficient numbers to ensure statewide access to evaluations and who are qualified to conduct an evaluation to determine whether a defendant is mentally retarded as defined in section 18-1.3-1101(2), C.R.S.~~

~~C.The panel shall meet often enough to carry out its responsibilities, but no less than once per year. The panel shall ensure that each psychologist it recommends to the Executive panel shall meet often enough to carry out its responsibilities, but no less than once per year. The panel shall ensure that each psychologist it recommends to the Executive Director is currently licensed in the State of Colorado; has documentation of his/her experience and demonstrated competence in determination and evaluation of persons with[illegible] ; and, is willing to provide such evaluations when requested by the court.~~

8.607.2 DETERMINATION OF DEVELOPMENTAL DISABILITY

A. Any person, his/her legal guardian, parent(s) of a minor or such person(s) authorized by law may submit a written request for a determination of whether the applicant has a developmental disability.

B. A determination of developmental disability does not constitute a determination of eligibility for services or supports. The Community Centered Boards shall determine whether a person has a developmental disability and therefore may be eligible to receive services and supports pursuant to Sections 25.5-10-202(2) and 211, C.R.S., in accordance with criteria as specified by the Department.

Eligibility for Medicaid funded programs specific to persons with developmental disabilities shall be determined pursuant to the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 C.C.R. 2505-10).

C. The developmental disability determination shall be made according to Department procedures, which shall identify the qualifications of person(s) making such a determination.

D. A request for determination of developmental disability shall be submitted to the Community Centered Board in the designated service area where the person resides, including temporary residence such as incarceration or hospitalization.

E. At the time of request, the Community Centered Board shall:

1. Provide the applicant any required forms and a list of the minimum required documents and information necessary for the determination of developmental disability; and,

2. Provide the applicant with information on where to obtain testing for the level of intellectual functioning and adaptive behavior, if requested. The responsibility for obtaining such assessments shall be with the applicant and/or legal guardian.

F. The applicant and/or legal guardian shall provide all documentation and information necessary for the determination of developmental disability within ninety (90) calendar days of the request.

1. The Community Centered Board may request additional documentation and/or information, as needed, to complete the determination of developmental disability.

2. The applicant and/or legal guardian may have additional assessments completed and submitted to the Community Centered Board for consideration.

G. If the applicant and/or legal guardian has not provided the documentation and information necessary for the determination within ninety (90) calendar days of the request, the Community Centered Board shall:

1. Close the request and notify the applicant in writing according to the procedures established at Ssection 8.607.2.L.4; or,

2. The Community Centered Board may, at the request of the applicant and/or legal guardian, extend the deadline for providing the necessary documentation and information by up to an additional ninety (90) calendar days.

    a. In no case shall the deadline for providing the necessary documentation and information exceed one hundred eighty (180) calendar days.

    b. The Community Centered Board shall provide a written update to the applicant no less than every ninety (90) calendar days until a determination of developmental disability is completed or the request is closed.

    c. If the extended deadline for providing the necessary documentation and information has expired and there is still insufficient information to make a determination of developmental disability, the Community Centered Board shall close the request and notify the applicant and/or legal guardian in writing according to the procedures established at Ssection 8.607.2.L.4.

H. For all applicants, the Community Centered Board shall enter into the Department's designated data system and shall permanently maintain a written and/or electronic record of the developmental disability determination on a Department prescribed form. The record, at a minimum, shall include:

1. The name of the applicant;

2. The applicant's date of birth;

3. The date of the determination of developmental disability;

4. A description of the rationale for the developmental disability determination including, at minimum, assessment scores and diagnoses;

5. The name(s) and title(s) of the person(s) involved in making the determination.

I. All information and assessments used to determine a developmental disability shall be current so as to accurately represent the applicant's abilities at the time of determination.

1. Assessments of adaptive behavior shall have been completed within three (3) years of the request.

2. Assessments of intellectual functioning shall have been completed as follows:

    a. If an individual is between five (5) and eighteen (18) years of age, at least one intellectual assessment shall have been completed to determine the individual's impairment of general intellectual functioning; or,

    b. If an individual is eighteen (18) years of age or older and there is only one intellectual assessment available to determine the individual's impairment of general intellectual functioning, the assessment shall have been completed when the individual was at least eighteen (18) years of age and shall have been completed within ten (10) years of the request; or,

c. If there is historical pattern of consistent scores, based on two (2) or more intellectual assessments, that demonstrates an impairment of general intellectual functioning, the assessments may be used regardless of the individual's age at the time of determination.

3. An established neurological condition shall be documented as follows:

a. A diagnosed neurological condition shall be determined by a licensed medical professional practicing within the scope of his/her license; or,

b. If a specific diagnosis is not possible, a written statement from a licensed medical professional, practicing within the scope of his/her license, or a licensed psychologist may be used as long as there is a documented effort to determine a diagnosis and the available assessment information reasonably supports a conclusion that a neurological impairment is present.

4. The effects of mental illness or physical or sensory impairment must be considered to determine the extent to which such impairments are the sole contributing factor to the impairment of general intellectual functioning or limitations to adaptive behavior.

J. Prior to July 1, 2015, the Community Centered Board shall make the determination of developmental disability within ninety (90) calendar days of the receipt of all necessary information. On or after July 1, 2015, the Community Centered Board shall make the determination of developmental disability within thirty- (30) calendar days of the receipt of all necessary information.

K. The date of the developmental disability determination shall be the date that the Department prescribed form and all documentation and information necessary for the determination of developmental disability was received by the Community Centered Board.

If a delay to the determination of developmental disability is due to the actions or inactions of the Community Centered Board, the original date of request shall be used.

L. The Community Centered Board making the developmental disability determination shall, in writing, notify the applicant or legal guardian, and the authorized person requesting the determination, if other than the applicant or legal guardian, and other such persons as designated by the applicant, of the decision. Such notification shall:

1. Be mailed to the person within seven (7) calendar days of the date of determination;

2. Be provided in such alternative means of communication as to reasonably ensure that the information has been communicated in an understandable form; and,

3. For persons determined to have a developmental disability, contain an explanation of the process that will occur and notice that, at a minimum, an Individualized Plan shall be developed upon enrollment into a developmental disability service;

4. For persons determined not to have a developmental disability or persons whose request is closed without the determination of a developmental disability, state the reasons for the determination or closure, and provide a written For persons determined not to have a developmental disability or persons whose request is closed without the determination of a developmental disability, state the reasons for the determination or closure, and provide a written ~~Long Term~~Long-Term Care Notice of Action form in accordance with the provisions of Ssection 8.057~~, et seq. of the Colorado Department of Health Care Policy~~

~~and Financing's medical assistance rules (10 C.C.R. 2505-10)~~ regarding the applicant's right to appeal the decision to the Office of Administrative Courts.

M. Applicants determined not to have a developmental disability may request a new determination of developmental disability at any time upon receipt of new or missing required information, and a new request date shall be established.

N. A determination of developmental disability shall be accepted by other Community Centered Boards, service agencies and regional centers.

O. A determination of developmental disability shall be permanent and shall not require renewal or review unless:

1. The interdisciplinary team determines that developmental disability services are no longer needed due to improvement in a person's condition and recommends a redetermination; or,

2. Information from a new evaluation becomes available which demonstrates sufficient improvement in a person's condition such that the determination should be reviewed.

8.607.3 SERVICE AND SUPPORT COORDINATION

A. Service and support coordination shall be the responsibility of the community centered boards and regional centers. Service and support coordination shall be provided in partnership with the person receiving services, the parents of a minor, legal guardian and public and private agencies to the extent such partnership is requested by these individuals. Persons receiving services who are their own guardians may also request their family or others to participate in this partnership.

B. Service and support coordination shall assist the eligible person to ensure:

1. An Individualized Plan is developed, utilizing necessary information for the preparation of the Individualized Plan and using the Interdisciplinary Team process;

2. Facilitating access to and provision of services and supports identified in the Individualized Plan;

3. The coordination of services and supports identified in the Individualized Plan for continuity of service provision; and,

4. The Individualized Plan is reviewed periodically, as needed, to determine the results achieved, if the needs of the person receiving services are accurately reflected in the Individualized Plan, whether the services and supports identified in the Individualized Plan are appropriate to meet the person's needs and what actions are necessary for the plan to be achieved.

8.607.4 INDIVIDUALIZED PLAN (IP)

A. Under the coordination and direction of the community centered board or regional center, the Interdisciplinary Team (IDT) shall develop the Individualized Plan (IP).

B. There shall be at least ten (10) days written notice from the ~~postmarked~~timestamped date given to all Interdisciplinary Team members prior to an Individualized Plan meeting unless waived by the person receiving services or guardian as necessary and desirable.

Every effort shall be made to convene the meeting at a time and place convenient to the person receiving services, their legal guardian, authorized representative and parent(s) of a minor. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

C. The community centered board, and service agency or regional center as applicable, shall make available to the interdisciplinary team for each person receiving services such information as is necessary to develop the Individualized Plan.

D. The Individualized Plan shall:

1. Identify the unique strengths, abilities, preferences, desires, and needs of the person receiving services and their family, as appropriate;

2. Identify the specific services and supports appropriate to meet the needs of the eligible person, and family, as appropriate;

3. Document decisions made through the interdisciplinary team planning process including, but not limited to, rights suspension, the existence of appropriate services and supports, the actions necessary for the plan to be achieved, including which services and supports will be addressed through the development of an Individual Service and Support Plan (ISSP). The services and supports funded by the Department to be provided shall be described in sufficient detail as to provide for a clear understanding by the service agency(ies) of expected responsibilities and performance;

4. Describe the results to be obtained from the provision of services and supports identified in the Individualized Plan;

5. Document the authorized services and supports funded by the Department and the projected date of initiation;

6. Identify a contingency plan for how necessary care for medical purposes will be provided in the event that the person's family or caregiver is unavailable due to an emergency situation or to unforeseen circumstances. “Medical purposes” refers to a medical condition that places the individual at risk of not surviving, and that requires the support of persons qualified to address the specific medical needs of the person receiving services. Such medical conditions include, but are not limited to:

   a. Dependency on technology, such as respirators, tracheotomy tubes, or ventilators;

   b. Monitoring of medical equipment, such as a heart monitor; or,

   c. Uncontrolled seizures for which a response while receiving services is likely.

   A contingency plan is not needed for non-medical purposes or if the person receiving services does not have specific medical needs that would place him/her at risk because of the unavailability of the family or service provider. The development of a contingency plan in and of itself does not create an entitlement for services, for which none existed before.

7. Have a listing of the Interdisciplinary Team participants and their relationship to the person receiving services; and,

8. Contain a statement of agreement with the plan signed by the person receiving services or other such person legally authorized to sign on behalf of the person and a representative of the community centered board or regional center. The case manager may accept digital signatures on the agreement.

E. Copies of the Individualized Plan shall be disseminated to all persons involved in implementing the Individualized Plan including the person receiving services, their legal guardian, authorized representative and parent(s) of a minor, and the Department or others, as necessary and appropriate. If requested, copies shall be made available prior to the provision of services or supports; or within a reasonable period of time not to exceed thirty (30) days from the development of the Individualized Plan and in accordance with these rules.

F. The Individualized Plan shall remain in effect for a period not to exceed one year without review, and shall be reviewed and amended more frequently by the Interdisciplinary Team, as determined necessary and appropriate by Interdisciplinary Team members in order that the Individualized Plan accurately reflects the eligible person's current needs and circumstances. The community centered board or regional center shall coordinate the scheduling of such reviews.

8.607.5 OBTAINING SERVICES AND SUPPORTS

A~~A~~. Each community centered board shall establish and maintain a system to disseminate a Request for Provider (RFP) for clients who are seeking a Program Approved Provider Agency and to refer the client to approved providers who respond to the RFP. ~~a Referral and Placement Committee (RPC) which shall be an interdisciplinary or interagency committee responsible for making recommendations regarding the following:~~

~~1.Enrollment into Title XIX Medicaid programs administered by the Department; and,~~

~~2.Referral to a regional center for long-term or short-term placement; and,~~

~~3.Referrals to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) for placement pursuant to rules of the Colorado Department of Health Care Policy and Financing's Medical Assistance Manual (10 C.C.R. 2505-10).~~

~~B.The person receiving services, their legal guardian, authorized representative, and parent(s) of a minor shall be invited to attend and participate in any Referral and Placement Committee review which pertains to them.~~

~~C.Each community centered board shall specify the criteria and process by which an eligible person shall be considered for services and supports as funds are available. At a minimum, these shall include the following: within fifteen (15) days of receipt of a referral, program approved service agencies identified as appropriate service or support options shall notify in writing the person receiving services and the community centered board as to their decision.~~

B~~D~~. Each community centered board shall establish one (1) waiting list for services and supports for eligible persons for whom funding from the Department is unavailable. This waiting list shall be maintained in an up-to-date, consolidated written form as specified by the Department and managed pursuant to the rules of the Colorado Department of Health Care Policy and Financing's Medical Assistance Staff Manual (10 C.C.R. 2505-10), and the guidelines of the Department regarding waiting lists for Developmental Disabilities Services.

8.607.6 MONITORING

Regional centers shall be responsible to monitor the overall provision of services and supports authorized by the Department.

A. The frequency and level of monitoring shall meet the guidelines of the program in which the person is enrolled. At a minimum, monitoring shall include the following for each person:

1. The delivery and quality of services and supports identified in the Individualized Plan;

2. The health, safety and welfare of individuals;

3. The satisfaction with services and choice in providers; and,

4. That the regional center's and service agency's practices promote a person's ability to engage in self-determination, self-representation and self-advocacy.

B. A review of overall services and supports provided on an agency and system level shall be conducted to determine:

1. The general satisfaction of persons in regard to services and supports received;

2. The general practices of service agencies regarding health, safety and welfare of persons receiving services;

3. Fiscal compliance related to the implementation of Individualized Plans; and,

4. The nature and frequency of complaints regarding a service agency.

8.607.8 MEDICAID PROGRAMS FOR ~~PERSONS~~ INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

A. Regional Center Referral Process

1 A Client may be referred to a regional center for emergency short-term placement not to exceed ninety (90) days. Such referral shall be made as specified by the Colorado Department of Human Services (CDHS) and, at minimum, shall ensure that the CMA has exhausted all reasonable alternatives in an effort to procure or provide emergency services and supports in the Client's local community.

2. Clients may be referred to a regional center for long-term placement as specified by the CDHS. Such procedures shall include, but are not limited to:

A. The CMA responsible for case management services has notified the appropriate regional center and has involved the regional center in the evaluation process;

B. The CMA, Client, and the service planning team have reviewed and recommended placement;

C. All reasonable alternatives have been exhausted by the CMAto procure services and supports in the Client's local community and such efforts have been documented; and,

D. The Client or legal guardian is a resident of Colorado.

B. Nursing Facilities

For persons referred for a Preadmission Screening and Annual Resident Review (PASARR), the completion of the PASARR in accordance with the Department's guidelines, shall be the responsibility of the Community Centered Board in the area in which the person is physically residing, unless otherwise agreed upon by the Community Centered Boards affected.

8.608.6 INCIDENT REPORTING

A. Community centered boards, service agencies and regional centers shall have a written policy and procedure for the timely reporting, recording and reviewing of incidents which shall include, but not be limited to:

1. Injury to a person receiving services;
2. Lost or missing persons receiving services;
3. Medical emergencies involving persons receiving services;
4. Hospitalization of persons receiving services;
5. Death of person receiving services;
6. Errors in medication administration;
7. Incidents or reports of actions by persons receiving services that are unusual and require review;
8. Allegations of abuse, mistreatment, neglect, or exploitation;
9. Use of safety control procedures;
10. Use of emergency control procedures; and,
11. Stolen personal property belonging to a person receiving services.

B. Reports of incidents shall include, but not be limited to:

1. Name of the person reporting;
2. Name of the person receiving services who was involved in the incident;
3. Name of persons involved or witnessing the incident;
4. Type of incident;
5. Description of the incident;
6. Date and place of occurrence;
7. Duration of the incident;
8. Description of the action taken;
9. Whether the incident was observed directly or reported to the agency;

10. Names of persons notified;

11. Follow-up action taken or where to find documentation of further follow-up; and,

12. Name of the person responsible for follow-up.

C. Allegations of abuse, mistreatment neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the agency administrator or designee, and to the community centered board within 24 hours.

D. Reports of incidents shall be-placed in the record of the person.

E. Records of incidents shall be made available to the community centered board, and the Department upon request.

F. Community centered boards, program approved service agencies and regional centers shall review and analyze information from incident reports to identify trends and problematic practices which may be occurring in specific services and shall take appropriate corrective action to address problematic practices identified.

G. Community centered boards must follow all critical incident reporting requirements outlined at Section 8.519.16 ~~et seq~~.

8.608.8 ABUSE, MISTREATMENT, NEGLECT, AND EXPLOITATION

A. Pursuant to Section 25.5-10-221, C.R.S., all Community Centered Boards, case management agencies, service agencies and regional centers shall prohibit abuse, mistreatment, neglect, or exploitation of any person receiving services.

B. Community Centered Boards, case management agencies, program approved service agencies and regional centers shall have written policies and procedures for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any person receiving services. These policies and procedures must be consistent with state law and:

1. Definitions of abuse, mistreatment, neglect, or exploitation must be consistent with state law and these rules;

2. Provide a mechanism for monitoring to detect instances of abuse, mistreatment, neglect, or exploitation. Monitoring is to include, at a minimum, the review of:

a. Incident reports;

b. Verbal and written reports of unusual or dramatic changes in behavior(s) of persons receiving services; and,

c. Verbal and written reports from persons receiving services, advocates, families, guardians, and friends of persons receiving services.

3. Provide procedures for reporting, reviewing, and investigating all allegations of abuse, mistreatment, neglect, or exploitation;

4. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and contractors who have engaged in abuse, mistreatment, neglect, or exploitation;

5. Ensure that employees and contractors are made aware of applicable state law and agency policies and procedures related to abuse, mistreatment, neglect or exploitation;

6. Require immediate reporting when observed by employees and contractors according to agency policy and procedures and to the agency administrator or his/her designee;

7. Require reporting of allegations within 24 hours to the parent of a minor, guardian, authorized representative, and Community Centered Board or regional center;

8. Ensure prompt action to protect the safety of the person receiving services. Such action may include any action that would protect the person(s) receiving services if determined necessary and appropriate by the service agency or Community Centered Board pending the outcome of the investigation. Actions may include, but are not limited to, removing the person from his/her residential and/or day services setting and removing or replacing staff;

9. Provide necessary victim supports;

10. Require prompt reporting of the allegation to appropriate authorities in accordance with statutory requirements and pursuant to Section 8.608.8.C ~~of these rules~~;

11. Ensure Human Rights Committee review of all allegations; and,

12. Ensure that no individual is coerced, intimidated, threatened or retaliated against because the individual, in good faith, makes a report of suspected abuse, mistreatment, neglect or exploitation or assists or participates in any manner in an investigation of such allegations in accordance with Section 8.608.8.D.

C. Any and all actual or suspected incidents of abuse, mistreatment, neglect, or exploitation shall be reported immediately to the agency administrator or designee. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, Section 19-~~1~~3-~~103~~304, C.R.S., (Colorado Children's Code), Section 18-6.5~~8~~-~~115~~108, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Section 26-3.1-102, C.R.S., (Human Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

D. All alleged incidents of abuse, mistreatment, neglect, or exploitation shall be thoroughly investigated in a timely manner using the specified investigation procedures. However, such procedures must not be used in lieu of investigations required by law or which may result from action initiated pursuant to Section C, ~~herein~~above.

1. Within ~~twenty-four~~24 hours of becoming aware of the incident, a ~~written~~critical incident report shall be made available to the agency administrator or designee and the Community Centered Board or regional center.

2. The agency shall maintain a written administrative record of all such investigations including:

   a. The incident report and preliminary results of the investigation;

b. A summary of the investigative procedures utilized;

c. The full investigative finding(s);

d. The actions taken; and,

e. Human Rights Committee review of the investigative report and the action taken on recommendations made by the committee.

3. The agency shall ensure that appropriate actions are taken when an allegation against an employee or contractor is substantiated, and that the results of the investigation are recorded, with the employee's or contractor's knowledge, in the employee's personnel or contractor's file.

8.612 SUPPORTS INTENSITY SCALE ASSESSMENT AND SUPPORT LEVELS

8.612.1 Supports Intensity Scale (SIS) Assessment [Eff. 2/1/12]

A. Completion of a Supports Intensity Scale (SIS) Assessment is a requirement for a Client to participate in the Home and Community Based Services-Supported Living Services (HCBS-SLS) or the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver. A Client or his or her guardian refusing to have a SIS assessment shall not be enrolled in the HCBS-SLS or HCBS-DD waivers.

B. Specific scores from the Client's SIS assessment shall be used in addition to other factors to obtain the Client's Support Level in the HCBS-DD and HCBS-SLS waivers.

C. The Community Centered Board (CCB) shall conduct a SIS assessment for a Client at the time of enrollment. Additional assessments will be conducted at a frequency determined by the Department.

D. The CCB shall:

1. Notify the Client, his or her legal guardian, authorized representative, or family member, as appropriate, of the requirement for and the right to participate in the SIS assessment.

2. Support and encourage the Client to participate in the SIS assessment. If the Client chooses not to participate in the SIS assessment, the CMA shall document his or her choice in the Client record on the Department required data system.

3. Schedule a SIS Interviewer to conduct the assessment. If the Client, his or her legal guardian, authorized representative, or family member, as appropriate, objects to the assigned SIS Interviewer, he or she shall be offered a choice of a different SIS Interviewer.

4. Assist the Client or other interdisciplinary team (IDT) members to identify at least two people who know the Client well enough to act as respondents for the SIS assessment. If at least two respondents cannot be identified, the CMA shall document the efforts to find two respondents and the reasons this could not be done and proceed with the assessment using the information available.

5. Upon Department approval, SIS assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

E. A qualified SIS Interviewer shall conduct the assessment. A SIS Interviewer shall not act as the respondent for a SIS assessment.

F. The CCB shall inform the Client, his or her legal guardian, authorized representative, or family member, as appropriate, of the purpose of the SIS, the SIS Complaint Process, the Support Level Review Process, and that he or she may receive a copy of the completed SIS assessment upon request. The CCB shall document that this information was provided and received on the SIS and Support Level disclosure form.

G. After the initial SIS assessment has been completed, the CMA shall conduct another SIS assessment for the Client only when approved by the Department through the following process:

1. Prior to a subsequent SIS assessment being conducted, the CMA shall submit a request to the Department for approval in the format prescribed by the Department.

2. The Department shall provide the CMA with a written decision regarding the request to conduct another SIS assessment within fifteen (15) business days after the date the request was received.

3. Upon receiving approval to conduct a subsequent SIS the CMA shall contact the designated CCB to request a SIS reassessment.

4. If the Client, his or her legal guardian, authorized representative or family member, as appropriate, disagrees with the decision, then a request for review of the decision may be submitted to the Executive Director of the Department within fifteen (15) business days after the date the decision was received.

5. The Executive Director or his or her designee shall review the request for conducting a SIS reassessment and provide a written decision within fifteen (15) business days.

6. The decision of the Executive Director or his or her designee shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.

H. A subsequent SIS assessment shall be conducted only when approved by the Department and when:

1. There has been a change in the Client's life circumstances or condition resulting in a significant change to the amount of services and supports needed to keep the Client safe;

2. The Client or his or her legal guardian, authorized representative, family member or case manager as appropriate, has reason to believe that the results of the most recent SIS assessment do not accurately reflect his or her current support needs; or,

3. The Department deems it necessary to complete a new assessment in order to ensure its accuracy.

I. Administration of the SIS assessments shall be reviewed by the Department for the purpose of quality assurance.

J. When the Department identifies SIS Interviewer practices that result in inaccurate SIS assessments:

1. Remediation efforts may occur to ensure that the SIS Interviewer performs assessments according to Department standards. The SIS Interviewer(s) who conducted the inaccurate SIS assessment(s) may be deemed no longer qualified to conduct SIS assessments.

2. Payments made for the administration of the inaccurate SIS assessments may be recovered through a repayment agreement; by offsetting the amount owed against current and future SIS determination payments; or, by any other appropriate action within the Department's legal authority.

3. The Client shall receive another SIS assessment conducted by a SIS Interviewer designated by the Department.

4. The Client's Support Level and Service Plan Authorization Limit will be adjusted as necessary and effective on the date determined by the Department.

b. The decision of the Executive Director or his or her designee shall constitute the final agency decision and will be subject to judicial review pursuant to Ssection 24-4-106, C.R.S.

E.The client shall be notified, pursuant to the Department of Health Care Policy and Financing rules in Ssection 8.057.2.A ~~(10 C.C.R. 2505-10)~~ when a waiver service is terminated, reduced, or denied. At any time, the client may pursue a Medicaid Fair Hearing in accordance with Ssection 8.057.3.A ~~(10 C.C.R. 2505-10)~~.

8.613 FAMILY SUPPORT SERVICES PROGRAM (FSSP)FAMILY SUPPORT SERVICES PROGRAM (FSSP)

A. ADMINISTRATION

1. The Community Centered Board (CCB) shall administer the Family Support Services Program (FSSP), subject to available appropriations and according to the rules, regulations, policies and guidelines of the Department, local Family Support Council (FSC) and CCB.

2. The CCB shall ensure that the FSSP is implemented within its designated service area.

3. The CCB shall designate one (1) person as the contact for the overall implementation and coordination of the FSSP.

4. Referrals to the FSSP shall be made through the CCB pursuant to ~~10 CCR 2505-10,~~ Section 8.607.

5. Nothing in these rules and regulations shall be construed as to prohibit or limit services and supports available to an individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay and their families which are authorized by other state or federal laws.

6. The CCB, in cooperation with the local FSC, shall ensure that the FSSP is publicized within the designated service area.

7. The CCB shall develop written policies and procedures for the implementation and ongoing operation of the FSSP, which must be kept on file and made available to the Department or the public, upon request.

B. FAMILY SUPPORT COUNCIL (FSC)

1. The CCB shall assist its designated service area to establish and maintain an FSC pursuant to Section 25.5-10-304, C.R.S.

2. The CCB shall establish an FSC roster that includes the names of members, type of membership and identifies the chairperson. The roster shall be available to the Department or the public, upon request.

3. Composition of the FSC:

   a. The majority of the members and the chairperson of each FSC shall be family members of an individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay.

   b. New members of the FSC shall be recruited from the service area. New members shall be approved by the current FSC and the board of directors of the CCB.

   c. The members of the FSC shall receive written notice of their appointment.

   d. The CCB shall ensure an orientation and necessary training regarding the duties and responsibilities of the FSC is available for all council members. The training and orientation shall be documented with a record of the date of the training, who provided the training, training topic, and names of attendees.

   e. The size of the FSC shall be sufficient to meet the intent and functions of the council, but no fewer than five (5) persons, unless approved by the Department.

   f. Each FSC shall establish the criteria for tenure of members, selection of new members, the structure of the council and, in conjunction with the CCB, a process for addressing disputes or disagreements between the FSC and the CCB. Such processes shall be documented in writing. Processes may include a request for mediation assistance from the Department.

4. The FSC duties include providing guidance and assistance to the CCB on the following:

   a. Overall implementation of the FSSP;

   b. Development of the written annual FSSP report for the designated service area, as defined at Section 8.613.M;

   c. Development of written procedures describing how families are prioritized for FSSP funding;

   d. Development of written policy defining how an emergency fund is established, funded and implemented. The policy must include a definition of a short-term

crisis or emergency and the maximum amount of funds a family may receive per event and/or year;

e. Provide recommendations on defining the “other” service category within the parameters as defined in this part;

f. Monitor the implementation of the overall services provided in the designated service area; and

g. Provide recommendations on how to assist families who are transitioning out of the FSSP.

C. ELIGIBILITY

1. Any individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay, as determined pursuant to Section 25.5-10-211, C.R.S., living with their family is eligible for the FSSP. Living with a family means that the individual's place of residence is with that family.

a. Living with family may include periods of time from one (1) day to up to six (6) months during which time the individual is not in his or her primary residence because of transition into or out of the home.

b. The CCB, in cooperation with the local FSC, shall determine what constitutes a transition.

2. The family and eligible individual shall reside in the State of Colorado.

3. All eligible individuals 18 and older must provide proof of lawful presence in the United States to receive FSSP funding.

4. Eligibility for the FSSP does not guarantee the availability of services or supports under this program.

D. WAITING LIST

1. The CCB shall maintain an accurate and up-to-date waiting list of eligible individuals for whom Department funding is unavailable in the current fiscal year.

2. In cooperation with the local FSC, the CCB shall develop written procedures for determining how and which individuals on the waiting list will be enrolled into the FSSP.

3. Individuals receiving ongoing FSSP funding shall not be listed on the waiting list for the program.

4. Individuals determined to be prioritized for FSSP funding shall be served prior to individuals determined at a lower level of prioritization.

5. The CCB must inform eligible families of the program and waiting list procedures and offer assessment and enrollment onto either the waiting list or the program, based on the assessment and available appropriations.

6. Any individual on the waiting list for FSSP may receive emergency funding through the CCB through the FSSP, if the needs meet the parameters set by the FSC and the CCB.

7. Waiting lists shall not exist for any CCB that does not expend all FSSP direct service funds.

E. PRIORITIZATION FOR FAMILY SUPPORT SERVICES PROGRAM (FSSP) FUNDING

1. CCBs must ensure that families with the highest assessed needs shall be prioritized for FSSP state funding.

2. CCBs, in conjunction with the FSC, will develop written procedures that describe how families shall be prioritized and notified of the prioritization process.

3. The assessment process shall be applied equally and consistently to all families who are assessed.

4. CCBs must distribute the prioritization process to families in their designated service area at the time the family requests FSSP funding, when the individual is placed on the waiting list, or upon request.

5. The CCB must notify families in writing of the results of the assessment.

6. All families, both on the waiting list and receiving FSSP services, shall be assessed for level of need on an annual basis or earlier if the family's circumstances change.

7. The assessment must contain the following components:

    a. The qualifying individual's disability and overall care need, which includes:

        i. The type of disability or condition and the need and complexity of medical or personal care for the individual;

        ii. The need for, frequency of, and amount of direct assistance required to care for the individual; and

        iii. The types of services needed that are above and beyond what is typically needed for any individual.

    b. The qualifying individual's behavioral concerns including how behaviors disrupt or impact the family's daily life, the level of supervision required to keep the individual and others safe, and the services and frequency required to help with the behaviors.

    c. The family composition, which considers obligations and limitations of the parent(s), the number of siblings, disabilities of other family members living in the home, and the level of stability of the family, such as pending divorce or age and disability of parents.

    d. The family's access to support networks, which includes the level of isolation or lack of support networks for the family, such as not having extended family nearby, living in rural areas or availability of providers.

    e. The family's access to resources such as family income, insurance coverage, HCBS waivers, and/or other private or public benefits.

F. DIRECT SERVICES

1. Services and supports available under the FSSP may be purchased from a variety of providers who are able to meet the individual needs of the family.

2. All services must be needed as a result of the individual's Intellectual and Developmental Disability (IDD) or Developmental Delay and shall not be approved if the need is a typical age-related need. Correlation between the need and the disability must be documented in the Family Support Plan (FSP).

3. All services must be provided in the most cost-effective manner, meaning the least expensive manner to meet the need.

4. All services shall be authorized pursuant to the FSP.

5. Services provided to the family through the FSSP shall not supplant third party funding sources available to the family including, but not limited to, public funding, insurance, or trust funds.

6. CCBs shall not charge a separate fee for assisting individuals to access services identified on the FSP.

7. FSSP funds shall not be used for any donation; religious , political , or otherwise or activities prohibited by law.

8. Direct Services

    a. Assistive technology is equipment or upgrades to equipment, which are necessary for the individual with an IDD or Developmental Delay to communicate through expressive and receptive communication, move through or manipulate his or her environment, control his or her environment, or remain safe in the family home.

    b. Environmental engineering is home or vehicle modification needed due to the individual's disability and is not a regular maintenance or modification needed by all owners. Modifications to the home or vehicle must be necessary due to the individual's IDD or Developmental Delay; or needed due to health and safety; or to allow the individual to attain more independence; and completed in a cost-effective manner. Cost-effective manner means the least expensive manner to meet the identified need. Home modifications are to be limited to the common areas of the home the individual with an IDD frequents, the individual's bedroom, and one bathroom. Other bedrooms and bathrooms shall not be modified. All devices and adaptations must be provided in accordance with applicable state or local building codes and/or applicable standards of manufacturing, design, and installation. Only homes or vehicles occupied and owned by the family where the eligible individual resides may be modified. Minor modifications may be made to rental units with the permission of the landlord. Rental modifications must be

made in a way that the modification can be moved with the eligible individual during a change in residence.

c. Medical and dental items prescribed by a licensed medical professional qualified to prescribe such items and are needed to maintain or attain physical health. Medical, dental, and vision services, exams and procedures are available when not covered by another source.

   i. Over the counter medications and vitamins are excluded, except as indicated at Section 8.800.4.D, when prescribed by a licensed medical professional qualified to write such prescriptions.

d. Other: Services in this category must be identified in the FSP, are specific to the family, and are limited to:

   i. A consultant and/or advocate to assist a family with accessing services outside of the CCB.

   ii. Recreational needs of the individual with an IDD or Developmental Delay when the need of recreation is above and beyond the typical need due to the disability or delay. The cost of family recreation passes shall be limited to $650 or one family pass, whichever is less, per fiscal year and shall be limited to use only at community recreation centers. The following items are specifically excluded under the FSSP and shall not be eligible for coverage:

      1) Entrance fees for zoos;

      2) Museums;

      3) Butterfly pavilion;

      4) Movie, theater, concerts;

      5) Professional and minor league sporting events;

      6) Outdoor play structures;

      7) Batteries for recreational items; and,

      8) Memberships to non-community gyms.

   iii. Specialized services as identified by the FSC and CCB, included in their written policy and are available to any family receiving ongoing Family Support Services Program assistance in the service area.

e. Parent and sibling support, which may include special resource materials or publications, cost of care for siblings, or behavioral services or counseling.

f. Professional services are services which require licensure or certification to treat a human condition other than medical, dental or vision, and is provided to the individual with an IDD or Developmental Delay. Professional services must be provided by qualified, certified and/or licensed personnel in accordance with the standards and practices of the industry. Professional services may include related support items or activities which are recommended as part of the therapy

with supporting documentation from the treating professional. Insurance expenses directly incurred by the individual with an IDD or Developmental Delay are included.

g. Program expenses are services related to serving multiple families and are funded through the direct service line.

i. This service is not identified in the individual's FSP. This service is provided by the CCB for the benefit of multiple families.

ii. Program expense is the maintenance, operation, or enhancement of a resource library that consists of an inventory of goods and equipment used to meet the needs of individuals with an IDD or Developmental Delay on a temporary basis.

iii. Program expense is the cost associated with participation with other community agencies in the development, maintenance, and operation of projects, supports or services that benefit individuals with an IDD or Developmental Delay.

iv. Program expense is the development or coordination of a training event for families.

v. Program expense is the cost of an event sponsored by the CCB for all eligible individuals and their families to meet other families to provide socialization and an opportunity to build a network of support.

vi. Program expense is the development and coordination of group respite.

vii. The FSC in conjunction with the CCB shall determine the maximum amount of direct services to be used for program expenses.

h. Respite is the temporary care of an individual with an IDD that provides relief to the family.

i. Transportation is the direct cost to the family that is higher than costs typically incurred by other families because of specialty medical appointments or therapies. Specialty medical appointments or therapies are defined as appointments needed due to the individual's IDD or Developmental Delay. The direct cost is the cost of transportation, lodging, food expense, and long-distance telephone calls to arrange for or coordinate medical services which are not covered by other sources.

G. CASE MANAGEMENT

Case management is the coordination of services provided for individuals with an IDD or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education, and other services to ensure non-duplication of services, and monitor the effective and efficient provision of services across multiple funding sources.

1. At minimum, the case manager is responsible for:

a. Determining initial and ongoing eligibility for the FSSP;

b. Development, application assistance, and annual re-evaluation of the Family Support Plan (FSP); and

c. Ensuring service delivery in accordance with the FSP.

2. Family Support Plan Requirements

a. Families enrolled into the FSSP shall have an individualized FSP which meets the requirements of an Individualized Plan, as defined in Sections 25.5-10-202 and 25.5-10-211, C.R.S., and includes the following information:

i. The name of the eligible individual;

ii. The names of family members living in the household;

iii.. The date the FSP was developed or revised;

iv. The prioritized needs requiring support as identified by the family;

v. The specific type of service or support, how it relates to the family need and the individual's disability or developmental delay, and period which is being committed to in the FSP, including, when applicable, the maximum amount of funds which can be spent for each service or support without amending the FSP;

vi. Documentation regarding cost-effectiveness of a service or support, which can include quotes, bids, or product comparisons but must include the reason for selecting a less cost-effective service or support, when applicable.

vii. A description of the desired results, including who is responsible for completion;

viii. The projected timelines for obtaining the service or support and, as appropriate, the frequency;

ix. A statement of agreement with the plan;

x. Signatures, which may include digital signatures of a family representative and an authorized CCB representative;

xi. The level of need;

xii. The length of time the funds are available; and

xiii. A description of how payment for the services or supports will be made.

b. The FSP shall integrate with other Service Plans affecting the family and avoid, where possible, any unnecessary duplication of services and supports. One FSP, inclusive of all eligible individuals with IDD or Developmental Delay shall be maintained per family.

c. The FSP shall be reviewed at least annually or on a more frequent basis if the plan is no longer reflective of the family's needs.

i. Any changes to the provision of services and supports identified in the FSP are subject to available funds within the designated service area.

ii. Any decision to modify, reduce or deny services or supports set forth in the FSP, without the family's agreement, are subject to the requirements in Section 8.605.

H. MANAGEMENT AND GENERAL ACTIVITIES

Management and general activities are the financial and corporate administration of the CCB specific to FSSP requirements by the Department.

I. EMERGENCY FUND

1. Each CCB shall establish an emergency fund that may be accessed by any individual eligible for the FSSP when needed due to an unexpected event that has a significant impact on the individual or family's health or safety and impacts the family's daily activities.

2. Any individual with an IDD or Developmental Delay determined by the CCB and living with family shall be eligible to receive emergency funds regardless of the enrollment status of the family.

3. The CCB in conjunction with the Family Support Council shall develop written policies and procedures regarding the Emergency Fund. At a minimum the policies and procedures must:

a. Define the purpose of the emergency fund;

b. Define an unexpected event and significant impact;

c. Describe the process for accessing emergency funds;

d. Describe how funding determination is made;

e. Give a timeline of the determination of the request;

f. Define the maximum funding amount per family or per event; and

g. Describe how families will be notified of the decision in writing.

J. BILLING AND PAYMENT PROCEDURES

1. The CCB shall develop and implement policies, procedures, and practices for maintaining documentation for the FSSP and reporting information in the format and timeframe established by the Department.

2. Families shall maintain and provide either receipts or invoices to the CCB documenting how funds provided to the family through the FSSP were expended. The CCB shall maintain supporting documentation capable of substantiating all expenditures and reimbursements made to providers and/or families, which shall be made available to the Department upon request.

a. When the CCB purchases services or items directly for families, the CCB shall maintain receipts or invoices from the service provider and documentation demonstrating that the provider was paid by the CCB. Receipts or invoices must contain, at a minimum, client and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount due or paid.

b. When the CCB reimburses families for services or items, the CCB shall ensure the family provides the CCB with receipts or invoices prior to reimbursement. The CCB shall maintain receipts or invoices from the families, and documentation demonstrating that the family was reimbursed by the CCB. The CCB must ensure all receipts or invoices provided by the families contain, at a minimum, client and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

c. When the CCB provides funding to the families for the purchase of services or items in advance, the CCB shall notify the families that they are required to submit invoices or receipts to the CCB of all purchases made prior to the close of the State Fiscal Year. The CCB must ensure that all receipts or invoices are collected and maintained from the family, as well as documentation demonstrating that the family received funding from the CCB. The CCB must ensure all receipts or invoices provided by the families contain, at a minimum, client and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

3. The CCB shall submit to the Department, on a form and frequency prescribed by the Department, information which outlines individual family use of the FSSP.

4. The CCB shall report only FSSP expenditure data in the format and timeframe as designated by the Department.

K. PROGRAM EVALUATION

1. The CCB, in cooperation with the local Family Support Council, shall be responsible for evaluating the effectiveness of the FSSP within its designated service area on an annual basis.

2. The evaluation may be based upon a family satisfaction survey and shall address the following areas:

a. Effectiveness of outreach/public awareness including:

i. The demographics of participants in comparison to demographics of the service area; and

ii. How well the program integrates with other community resources.

b. Satisfaction and program responsiveness to include:

i. Ease of access to the program;

ii. Timeliness of services;

iii. Effectiveness of services;

iv. Availability of services;

v. Responsiveness to family concerns;

vi. Overall family satisfaction with services; and

vii. Recommendations.

c. Effective coordination and utilization of funds to include:

i. Other local services and supports utilized in conjunction with the FSSP; and

ii. Efficiency of required documentation for receipt of the FSSP.

3. The CCB, and participating families as requested, shall cooperate with the Department regarding statewide evaluation and quality assurance activities, which includes, but is not limited to providing the following information:

a. The maximum amount any one family may receive through the FSSP during the fiscal year; and

b. The total number of families to be served during the year.

L. PERFORMANCE AND QUALITY REVIEW

1. The Department shall conduct a Performance and Quality Review of the FSSP to ensure that it complies with the requirements set forth in these rules.

2. A CCB found to be out of compliance with these rules through the results of the Performance and Quality Review, shall be required to develop a corrective action plan, upon written notification from the Department. A corrective action plan must be submitted to the Department within ten (10) business days of the receipt of the written request from the Department. A corrective action plan shall include, but not limited to:

a. A detailed description of the action to be taken, including any supporting documentation;

b. A detailed time frame specifying the actions to be taken;

c. Employee(s) responsible for implementing the actions; and

d. The implementation timeframes and a date for completion.

3. The CCB shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The agency shall explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the agency's compliance.

a. Upon receipt of the corrective action plan, the Department will accept, modify or reject the proposed corrective action plan. Modifications and rejections shall be accompanied by a written explanation.

b. In the event that the corrective action plan is rejected, the agency shall re-write the corrective action plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

c. The agency shall implement the corrective action plan upon acceptance by the Department.

d. If corrections are not made within the requested timeline and quality specified by the Department, funds may be withheld or suspended.

M. FAMILY SUPPORT SERVICES PROGRAM (FSSP) ANNUAL REPORT

1. Each CCB shall submit an annual FSSP report to the Department by October 1 of each year. The report will contain two sections.

a. The first section must describe how the CCB plans to spend the FSSP funds in the current fiscal year and will include:

i. Description of the outreach/public awareness efforts for the coming year;

ii. Description of anticipated special projects or activities under the Program Expense service category; and

iii. Goals with measurable outcomes for any changes to the FSSP.

b. The second section of the annual report will describe how the FSSP funds were spent in the previous year and must contain:

i. The program evaluation outcomes for the previous year as described in this section;

ii. The total amount of funds expended by service category;

iii. The total number of families served and the total number of families placed on the waiting list;

iv. Detailed information for the Program Expense service category to include:

1) The total number of families that utilized services under the Program Expense category;

2) The specific services provided; resource library, special projects, training events, social events, or group respite;

3) How these services enhanced the lives of families in the community and the total number of families who participated in each project; and

4) The report shall include the total number of staff, total of staff cost, and other costs associated with the Program Expense service category.

iv. A description of how the annual FSSP report was distributed to eligible families; and

v. The signature of Family Support Council (FSC) members, the FSSP Coordinator, and the CCB Executive Director.

8.761 TARGETED CASE MANAGEMENT (TCM) SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITITES

.14 Targeted Case Management services for Persons with Developmental Disabilities consists of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources. Targeted case management services includes the following activities:

a. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support. These assessment activities include:

1. Taking Client history; and

2. Identifying the Client's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators as necessary, to form a complete assessment of the Client.

b. Development and periodic revision of a specific care plan that:

1. Is based on the information collected through the assessment;

2. Specifies the goals and actions to address the medical, social, educational, and other services needed by the Client;

3. Includes activities such as ensuring the active participation of the Client, and working with the Client (or the Client representative as defined in Section 8.500.1) and others to develop those goals; and

4. Identifies a course of action to respond to the assessed needs of the Client.

c. Referral and related activities to help a Client obtain needed services including activities that help link a Client with:

1. Medical, social, educational providers; or

2. Other programs and services including making referrals to providers for needed services and scheduling appointments, as needed.

d. Monitoring and follow-up includes activities that are necessary to ensure the care plan is implemented and adequately addresses the Client's needs. Monitoring and follow up actions shall:

1. Be performed when necessary to address health and safety and services in the care plan;

2. Include activities to ensure:

   A. Services are being furnished in accordance with the Client's care plan;

   B. Services in the care plan are adequate; and

   C. Necessary adjustments in the care plan and service arrangements with providers are made if the needs of the Client have changed;

3. Include direct contact and observation with the Client in a place where services are delivered to a Client in accordance with the following frequency:

   A. Face-to-face monitoring shall be completed for a Client enrolled in HCBS-DD at least once per quarter;

   B. Face-to-face monitoring shall be completed for a Client enrolled in HCBS-SLS at least once per quarter;

   C. Face-to-face monitoring shall be completed for a Client in HCBS-CES at least once per quarter; and

   D. Face-to-face monitoring shall be completed at least once every six months for children in Early Intervention Services.

   E. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).