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Title of Rule: Revision to the Rural Health Center Rules Concerning Reimbursement, Section 8.740
Rule Number: MSB 21-07-20-C
Division / Contact / Phone: Rates / Erin Johnson / 4370

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 21-07-20-C, Revision to the Rural Health Center Rules Concerning Reimbursement, Section 8.740

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) 8.740, 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 8.740 with the proposed text beginning at 8.740.1 through the end of 8.740.7.F. This rule is effective January 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Rural Health Center Rules Concerning Reimbursement, Section 8.740
Rule Number: MSB 21-07-20-C
Division / Contact / Phone: Rates / Erin Johnson / 4370

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 will update Rural Health Center reimbursement and rate setting. This rule revision will clarify the Alternative Payment Rate setting methodology, interim rate setting for new Rural Health Clinics, Prospective Payment System rate setting for new Rural Health Clinics, and establish a scope of service rate adjustment process for Rural Health Clinics.

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

   Explain:

2. Federal authority for the Rule, if any:

   1902(bb) SSA

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Rural Health Center Rules Concerning Reimbursement, Section 8.740
Rule Number: MSB 21-07-20-C
Division / Contact / Phone: Rates / Erin Johnson / 4370

REGULATORY ANALYSIS

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

   Medicaid clients that receive care at Rural Health Clinics will be impacted by this rule. The rule will update the rate setting process for RHCs and will establish a scope of service rate adjustment process. These updates could impact RHC rates, by increasing them or decreasing them depending on the RHC's scope of service changes. No class of persons will bear any costs of the proposed rule.

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

   This rule will impact RHC rates. Updates to the language around APM rate setting, PPS rate setting, and interim rate setting for new RHCs will match our current policy and therefore have no quantitative impact. If RHCs utilize the scope of service rate adjustment process, their PPS rates could change. However, it is not possible to estimate which RHCs will apply for a rate adjustment or what that adjustment might be in the future. Changes to scope of service rate adjustment may increase or decrease RHC 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.

   There are no costs probable with this rule change.

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

   This rule will clarify the Department's RHC rate setting process. It also will establish a scope of service rate adjustment process, which is required by section 1902(bb) of the Social Security Act. Inaction will mean our rules are more vague on rate setting and we will be out of compliance with the scope of service rate adjustment requirements.

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 or less intrusive methods for achieving the purpose of this rule. The Department could keep the current rate setting language. Although it is correct, it is vague.

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

   The Department considered only updating the scope of service rate adjustment language and not the rate setting language. However, it is preferable to include more details in the rules on rate setting and to update some language to better match current rate setting policy.

8.740 RURAL HEALTH CLINICS

8.740.1 DEFINITIONS

Rural Health Clinic (RHC) means a clinic or center that:

1. Has been certified as a Rural Health Clinic under Medicare.

2. Is located in a rural area, which is an area that is not delineated as an urbanized area by the Bureau of the Census.

3. Has been designated by the Secretary of Health and Human Services as a Health Professional Shortage Area (HPSA) through the Colorado Department of Public Health and Environment.

4. Is not a rehabilitation facility or a facility primarily for the care and treatment of mental diseases.

Visit means a face-to-face encounter, or an interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounter between a clinic client and ~~any~~ a health professional providing the services set forth in 8.740.4. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care.

8.740.2 REQUIREMENTS FOR PARTICIPATION

8.740.2.A. A Rural Health Clinic shall be certified under Medicare.

8.740.2.B. A Rural Health Clinic providing laboratory services shall be certified as a clinical laboratory in accordance with 10 C.C.R 2505-10, Section 8.660.

8.740.3 CLIENT CARE POLICIES

8.740.3.A. The Rural Health Clinic's health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the Rural Health Clinic staff.

8.740.3.B. The policies shall include:

1. A description of the services the Rural Health Clinic furnishes directly and those furnished through agreement or arrangement. See section 8.740.4.A.4.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the Rural Health Clinic.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.740.4 SERVICES

8.740.4.A. The following services may be provided by a certified Rural Health Clinic:

1. General services

    a. Outpatient primary care services that are furnished by a physician assistant, clinical psychologist, clinical social worker, nurse practitioner, nurse midwife, licensed professional counselor, licensed marriage and family therapist, or licensed addiction counselor as defined in their respective practice acts.

    b. Part-time or intermittent visiting nurse care.

    c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.740.4.A.1.a and b.

2. Laboratory services. Rural Health Clinics furnish basic laboratory services essential to the immediate diagnosis and treatment of the client.

3. Emergency services. Rural Health Clinics furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

4. Services provided through agreements or arrangements. The Rural Health Clinic has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including inpatient hospital care; physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the Rural Health Clinic.

8.740.5 PHYSICIAN RESPONSIBILITIES

8.740.5.A. A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on client referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.740.6 ALLOWABLE COSTS

8.740.6.A. The following types and items of cost shall be included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician who owns, is employed by, or furnishes services under contract to a Rural Health Clinic.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies incident to the services of a physician, physician assistant, clinical psychologist, clinical social worker, nurse practitioner, nurse-midwife, licensed professional counselor, licensed marriage and family therapist, or licensed addiction counselor.

4. Overhead costs, including clinic or center administration, costs applicable to use and maintenance of the entity and depreciation costs.

5. Costs of services purchased by the Rural Health Clinic.

8.740.7 REIMBURSEMENT

8.740.7.A. The Department shall reimburse Rural Health Clinics a per visit encounter rate. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. An RHC may be reimbursed for up to two separate encounters with the same client occurring in the same day and at the same location, so long as the two encounters submitted for reimbursement are a physical health and a behavioral health service.

8.740.7.B. Rural Health Clinic rates are updated annually on January 1st.

The encounter rate shall be the higher of:

1. The Prospective Payment System (PPS), as defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, BIPA is incorporated herein by reference. No amendments or later editions are incorporated. The Acute Care Benefits Section Manager at the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of BIPA, or the materials may be examined at any publications depository library.

2. The Alternative Payment Methodology (APM)~~Medicare~~ rate.

   a. The ~~Medicare~~ APM rate for hospital based Rural Health Clinics ~~with fewer than 50 beds~~ shall be based on actual costs.

      i. The interim rate for Rural Health Clinics shall be the higher of the current year PPS rate and the most recent audited and finalized cost per visit from the Medicare cost report.

      ii. After a Rural Health Clinic's Medicare cost report has been audited and finalized, the Department shall perform a reconciliation for the services provided by the Rural Health Clinic during the year the cost report covers. If the Department's interim rate was below the finalized rate, a one-time payment will be made to the Rural Health Clinic. If the Department's interim rate was above the finalized rate and the PPS rate, the Department will recoup the difference from the RHC.

   b. The ~~Medicare~~ APM rate for ~~all other~~freestanding Rural Health Clinics is the Medicare upper payment limit for Rural Health Clinics.

8.740.7.C. New RHCs shall be reimbursed an interim per visit encounter rate, which shall be calculated as follows:

1. For new freestanding RHCs, the interim rate will be the average of other freestanding RHC's APM rates in the new RHC's Regional Accountable Entity (RAE).

2. For new hospital-based RHCs, the interim rate will be calculated based on the following options in the following order:

   a. The per visit encounter rate established by a Medicare rate letter; or

   b. A sister clinic's per visit encounter rate.

A hospital-based RHC's interim rate will be updated if the RHC provides an updated Medicare rate letter. The new rate will be effective the following January 1st.

8.740.7.D. PPS rates for new RHCs shall be calculated as follows:

1. For new freestanding RHCs, the PPS rate shall be calculated based on the average of other freestanding RHC's PPS rates in the new RHC's RAE.

2. For new hospital-based RHCs, the PPS rate shall be calculated based on an average of two year's audited cost and visit data from the RHC's Medicare cost report.

8.740.7.E~~C~~. The Department will reimburse Long-Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices separate from the Rural Health Clinic per visit encounter rate. Reimbursement will be the lower of:

1. 340B acquisition costs;

2. Submitted charges; or

3. Fee schedule as determined by the Department.

8.740.7.F. PPS Change in Scope

1. If an RHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the RHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.
   a. An RHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the RHC. The documented change in the scope of service of the RHC must meet all of the following conditions:
      i. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act and is furnished by the RHC.
      ii. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5
      iii. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.
      iv. The net change in the RHC's per-visit encounter rate equals or exceeds 3% for the affected RHC. For RHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with the scope-of-service change.
      v. The change in scope must have existed for at least a full six (6) months.
   b. A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.740.7.F.1.a. and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.
      i. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;
      ii. The addition or deletion of a covered Medicaid service under the State Plan;

iii. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;
iv. Changes in service due to a change in applicable technology and/or medical practices utilized by the RHC;
v. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;
vi. Changes resulting from a change in the provider mix, including, but not limited to:

a. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the RHC;

b. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the RHC (e.g. delivery services);

c. Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or,

d. Changes in the operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the RHC, provided that those expenditures result in a change in the services provided by the RHC.

c. The following ~~items~~are examples of items that do not prompt a scope-of-service rate adjustment:
i. An increase or decrease in the cost of supplies or existing services;
ii. An increase or decrease in the number of encounters;
iii. Changes in office hours or location not directly related to a change in scope of service;
iv. Changes in equipment or supplies not directly related to a change in scope of service;
v. Expansion or remodel not directly related to a change in scope of service;
vi. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;
vii. The addition or removal of administrative staff;
viii. The addition or removal of staff members to or from an existing service;
ix. Changes in salaries and benefits not directly related to a change in scope of service.
x. Change in patient type and volume without changes in type, duration, or intensity of services;
xi. Capital expenditures for losses covered by insurance; or,
xii. A change in ownership.

d. An RHC must apply to the Department by written notice within one hundred and fifty (150) days of the end of the RHC's fiscal year in which the change in scope of service occurred. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.740.7.F.1.a.iv, the RHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the

year after. For example, if a valid change in scope of service that occurred in FY 2021 fails to reach the threshold needed for the rate adjustment, and the RHC implements another valid change in scope of service during FY 2022, the RHC may submit a scope-of-service rate adjustment application that captures both of those changes. An RHC may only combine changes in scope of service that occur within a three-year time ~~frame, and~~frame and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope of service rate adjustment.~~.~~

f. The documentation for the scope-of-service rate adjustment is the responsibility of the RHC. Any RHC requesting a scope-of-service rate adjustment must submit the following to the Department:

i. The Department's application form for a scope-of-service rate adjustment, which includes;

a. The provider number(s) that is/are affected by the change(s) in scope of service;

b. A date on which the change(s) in scope of service was/were implemented;

c. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

d. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

e. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the RHC;

ii. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the RHC must provide the additional documentation within thirty (30) days. If the RHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

g. The reimbursement rate for a scope-of-service change applied for January 1, 2022 or afterwards will be calculated as follows:

i. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also calculate the Adjustment Factor (AF = covered health care costs/total cost of RHC services) associated with the change in scope of service of the RHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the RHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the RHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

ii. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

iii. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The "current PPS rate" means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

iv. The Department will check that the adjusted PPS rate meets the 3% threshold above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

v. Once the Department has determined that the Adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.

h. The Department will review the submitted documentation and will notify the RHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect the following January 1st.

j. An RHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, an RHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The RHC should also include any documentation that supports its positions. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Consumer Directed Attendant Support Services EVV Compliance, Section 8.510
Rule Number: MSB 21-08-04-B
Division / Contact / Phone: Benefits and Management Section / Katherine McGuire / 303-866-6313

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 21-08-04-B, Revision to the Medical Assistance Act Rule concerning Consumer Directed Attendant Support Services EVV Compliance, Section 8.510

3. This action is an adoption of: an amendment

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

   Sections(s) 8.510, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.510 wit the proposed text beginning at 8.510.1 through the end of 8.510.18.D. This rule is effective January 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Consumer Directed Attendant Support Services EVV Compliance, Section 8.510
Rule Number: MSB 21-08-04-B
Division / Contact / Phone: Benefits and Management Section / Katherine McGuire / 303-866-6313

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 Consumer Directed Attendant Support Services to incorporate Electronic Visit Verification requirements, establish responsibilities and policies for client or Authorized Representative non-compliance.

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, 42 U.S.C. § 1396b(l)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Consumer Directed Attendant Support Services EVV Compliance, Section 8.510
Rule Number: MSB 21-08-04-B
Division / Contact / Phone: Benefits and Management Section / Katherine McGuire / 303-866-6313

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.

   Consumer Directed Attendant Support Services (CDASS) is a participant-directed service delivery option serving participants on the Home and Community Based Services Elderly Blind and Disabled (EBD), Community Mental Health Services (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI) and Supported Living Services (SLS) waivers. CDASS rules are found at 10 C.C.R. 2505-10 § 8.510.

   The 21st Century Cures Act requires all state Medicaid agencies implement an Electronic Visit Verification (EVV) solution for Personal Care and Home Health Services. As of August 3, 2020, EVV became mandated by Section 8.001 for all Colorado-required EVV services, including Consumer Directed Attendant Support Services (CDASS). It is the responsibility of the CDASS employer (the member or their authorized representative) to comply with the EVV requirement. Failure to comply with EVV violates federal law and state rule. Select members may be exempt from the mandate due to an American with Disabilities Act accommodation or Live-in Caregiver exemption.

   The Department proposes an amendment to rules for the implementation of the CDASS EVV Compliance Protocol. The rule revision updates roles and responsibilities of members and authorized representatives (ARs) to include EVV compliance.

   This protocol monitors monthly compliance with EVV and assigns a strike to the member if EVV compliance is below 80 percent. Each strike has a unique consequence, concluding with termination from the CDASS program for 365 days on the 5th strike. The goal of the protocol is to improve EVV performance, not to terminate members from CDASS. On January 1st of every year, strike accumulation resets.

   The Department is implementing the CDASS EVV Compliance Protocol to outline clear processes to ensure members who are directing and managing their own care are aware of the requirements and consequences for episodes of non-compliance. In CDASS, members/ARs are the legal employer of record for their attendants. As

the employer, the member/AR is responsible for performing and managing certain functions in lieu if an agency being the provider. The revision of the rule is to align with existing rules in section 8.001 and include CDASS specific compliance measures.

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

   Members who are currently following EVV requirements, and continue to do so, will not be impacted by this rule. Members who are consistently not following EVV requirements will experience an impact if non-compliance continues to the 5th strike. This rule change will establish solutions for members who are consistently non-compliant with EVV. Those members who are terminated from CDASS for 365 days will receive support and service planning from the case manager to ensure that their care needs are met.

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 for the implementation of the rule and enforcement. The Department contracts with the FMS vendors, case management agencies, and a training and operations vendor to implement changes.

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

   There are no probable costs to the Department and the cost of inaction would be non-compliance with the 21st Century Cures Act. CMS is permitted to reduce FMAP for non-compliant services. The proposed rule change is to identify the additional roles and responsibilities for EVV compliance specific to members enrolled in CDASS. This change additionally adds measures for accountability that aligns with the uniqueness of members being the legal employer.

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

   The Department is not experiencing an increase in costs associated with the rule change. The rule change is to have parameters and process for a requirement already implemented in Colorado to meet federal compliance.

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.

DO NOT PUBLISH THIS PAGE

There are no alternative methods for achieving necessary compliance with EVV. The Department must ensure CDASS members are compliant with state and federal laws. Currently, CDASS members are not adequately complying with the EVV requirement. This rule revision enhances EVV requirements already in place as outlined in CCR 8.001.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

A. ~~A.~~ Adaptive Equipment means one or more devices used to assist with completing activities of daily living.

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

D. ~~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 or Authorized Representative through the contracted FMS vendor.

E. ~~E.~~ Attendant Support Management Plan (ASMP) means the documented plan described in 8.510.5, detailing management of Attendant support needs through CDASS.

F. ~~F.~~ Authorized Representative (AR) means an individual designated by the Client or the Client's legal guardian, if applicable, who has the judgment and ability to direct CDASS on a Client's behalf and meets the qualifications contained in 8.510.6 and 8.510.7.

G. ~~G.~~ Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6-106, C.R.S., and has a current provider participation agreement with the Department.

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

I. ~~I.~~ Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that empowers 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. ~~J.~~ CDASS Certification Period Allocation means the funds determined by the Case Manager and made available by the Department for Attendant services for the date span the Client is approved to receive CDASS within the annual certification period.

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

L. ~~L.~~ CDASS Training means the required CDASS training and comprehensive assessment provided by the Training and Operations Vendor to a Client or Authorized Representative.

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

N. 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.

~~M.~~ .

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

~~O.~~P. ~~O.~~ Financial Eligibility means the Health First Colorado financial eligibility criteria based on Client income and resources.

~~P.~~Q. ~~P.~~ Financial Management Services (FMS) vendor means an entity contracted with the Department and chosen by the Client or Authorized Representative to complete employment-related functions for CDASS Attendants and to track and report on individual Client CDASS Allocations.

~~Q.~~R. ~~Q.~~ Fiscal/Employer Agent (F/EA) provides FMS by performing payroll and administrative functions for Clients receiving CDASS benefits. The F/EA pays Attendants for CDASS services and maintains workers' compensation policies on the Client-employer's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both Client-employer and Attendant-employee Social Security and Medicare taxes.

~~R.~~S. ~~R.~~ Functional Eligibility means the physical and cognitive functioning criteria a Client must meet to qualify for a Medicaid waiver program, as determined by the Department's functional eligibility assessment tool.

~~S.~~T. ~~S.~~ Home and Community-based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to Clients in community settings. These services are designed to help older persons and persons with disabilities to live in the community.

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

~~V.~~W. ~~V.~~ Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the Client.

~~W.~~X. ~~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 account statements, Case Manager contact, or FMS vendor contact.

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

~~Y.~~Z. ~~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 Clients, Authorized Representatives, and Case Managers.

8.510.2 ELIGIBILITY

8.510.2.A. To be eligible for the CDASS delivery option, the 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 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's primary care physician, physician assistant, or advanced practice nurse, attesting to the Client's ability to direct their care with sound judgment or a required AR with the ability to direct the care on the 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 training obligations

        i. 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's previous service utilization and consult with the Department to determine whether full retraining is required, or an abbreviated training based on history of managing allocation and services is needed.

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

8.510.3 COVERED SERVICES

8.510.3.A. Covered services shall be for the benefit of only the Client and not for the benefit of other persons.

8.510.3.B. Services include:

1. Homemaker: General household activities provided by an Attendant in a Client's home to maintain a healthy and safe environment for the Client. Homemaker activities shall be provided only in the primary living space of the 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 in the community or in the Client's home to meet the 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'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 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 is able to assist or direct.

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

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

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

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

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

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

k. Cleaning and basic maintenance of durable medical equipment.

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

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

3. Health Maintenance Activities: Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible Client in the community or in the Client's home, which are necessary for health and normal bodily functioning that a person with a disability is physically unable to 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 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 is unable to participate in the task;

      iv) Oral suctioning is required;

      v) There is decreased oral sensitivity or hypersensitivity;

      vi) Client is at risk for choking and aspiration.

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

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

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

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

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

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

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

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

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

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

f. Exercise prescribed by a Licensed Medical Professional, including passive range of motion.

g. Transferring a Client when they are not able to perform transfers independently due to illness, injury or disability, or:

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

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

   iii) The use of a mechanical lift is needed.

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

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

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

   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 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 requires health maintenance-level skin care, transfers or dressing in conjunction with bathing.

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

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

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

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

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

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

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

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

ii) The Client is unable to complete task independently

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

a. Homemaker services, as defined at 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 is admitted to a nursing facility, hospital, a long-term care facility or incarcerated;

2. Following the death of Client;

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

Companionship is not a covered CDASS service.

8.510.5 ATTENDANT SUPPORT MANAGEMENT PLAN

8.510.5.A. The Client/AR shall develop a written ASMP after completion of training but prior to the start date of services, which shall be reviewed by the Training and Operations Vendor and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date to the FMS. The ASMP is required following initial training and retraining and shall be modified when there is a change in the Client's needs. The plan shall describe the 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'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 or AR has the right to review the disapproval. The Client or AR shall submit a written request to the CMA stating the reason for the review and justification of the proposed ASMP. The Client's most recently approved ASMP shall remain in effect while the review is in process.

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

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

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

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

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

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's monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the Client or AR for reimbursement through the FMS vendor.

15. Authorize Attendant to perform services allowed through CDASS.

16. Ensure all Attendants required to utilize EVV are trained and complete EVV for services rendered. Timesheets shall be reviewed and reflect time worked that all required data points are captured to maintain compliance with 8.001.

~~16.~~17. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and Client/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS.

~~17~~18. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement.

~~18~~19. Authorize the FMS vendor to make any changes in the Attendant wages.

~~19~~20. 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.

2~~0~~1. 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/AR may request a reassessment if the Client's level of service needs have changed.

7. A 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.

8.510.7.B. CDASS Clients who require an AR may not serve as an AR for another CDASS 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 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 to the satisfaction of the 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 Clients collectively.

8.510.8.C. An AR shall not be employed as an Attendant for the same 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 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/AR not to exceed the amount established by the Department. The FMS vendor shall make all payments from the Client's Allocation under the direction of the Client/AR within the limits established by the Department.

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

8.510.8.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/AR and timelines established by the Colorado Department of Labor and Employment.

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

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

6. Track and report utilization of 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 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/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/AR may select a new FMS vendor during the designated open enrollment periods. The Client/AR shall remain with the selected FMS vendor until the 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 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 has a minimum of two approved Attendants prior to starting CDASS. The 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/AR with employee numbers and confirms Attendants' employment status.

8.510.11.E. If a 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'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 from any other Medicaid-funded Attendant support including 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.

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/AR fails to meet their CDASS responsibilities, the Client may be terminated from CDASS. Prior to a 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/AR does not comply with CDASS program requirements including service exclusions.

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

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

4. The Client/AR spends the monthly Allocation in a manner 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/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/AR authorizes the Attendant to perform services while the 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. Clients may be involuntarily terminated immediately from CDASS for the following reasons:

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

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

3. The Client/AR exhibits Inappropriate Behavior as defined at 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/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

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

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/AR fails to complete retraining, appoint an AR, or remediate CDASS management per 8.510.13.A.

8. Client/AR demonstrates a consistent pattern of non-compliance with EVV requirements determined by the EVV CDASS pProtocol.

   a. Members experiencing FMS EVV systems issues must notify the FMS Vendor and/or Department of the issue within 5 business days. In the event of a confirmed FMS EVV system outage or failure impacting EVV submissions, the Department will not impose strikes or pursue termination, as appropriate, as outlined in the EVV Compliance protocol.

8.510.15 ENDING THE CDASS DELIVERY OPTION

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

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

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

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

8.510.15.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 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 must meet all CDASS eligibility requirements with the AR completing CDASS training prior to enrollment in CDASS.

8.510.15.F. Clients who are involuntarily terminated pursuant to 8.510.14.A.8 are eligible for enrollment in CDASS 365 days from the date of termination. The Client must meet all eligibility requirements and complete 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/AR. The Case Manager shall notify the 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's CDASS needs, the Case Manager shall work with the Client/AR to complete a fully developed ASMP.

8.510.16.C. The Case Manager shall calculate the Allocation for each 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's Allocation.

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

3. Allocations that exceed care in an institutional setting cannot be authorized by the Case Manager without Department approval. The Case Manager will follow the Department's over-cost containment process and receive authorization prior to authorizing a start date for Attendant services.

8.510.16.D. Prior to training or when an Allocation changes, the Case Manager shall provide written Notification of the Allocation to the Client and the AR, if applicable.

8.510.16.E. A Client or AR who believes the 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/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/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 of CDASS Allocation approval or disapproval by providing a long-term care notice of action form to Clients within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

8.510.16.F. In approving an increase in the Client's Allocation, the Case Manager shall consider all of the following:

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

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

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

8.510.16.G. In reducing a 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'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's CDASS start date.

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

1. Contact the CDASS Client/AR once a month during the first three months to assess their CDASS management, their satisfaction with Attendants, and the quality of services received. Case Managers may refer 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/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/AR when a change in AR occurs and contact the Client/AR once a month for three months after the change takes place.

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

5. Utilize Department overspending protocol when needed to assist CDASS Client/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'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'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/AR hiring the Attendant. The FMS vendor shall make all payments from the Client's Allocation under the direction of the Client/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified in the ASMP.

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

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

8.510.17.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/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/AR and be supervised by the 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'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 and avoid institutionalization. Extraordinary care shall be documented on the service plan.

8.510.18.D. A Client/AR who chooses a Family Member as a care provider, shall document the choice on the ASMP.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning In-Home Support Services, Section 8.552
Rule Number: MSB 21-06-09-A
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 21-06-09-A, Revision to the Medical Assistance Act Rule concerning In-Home Support Services, Section 8.552

3. This action is an adoption of: an amendment

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

   10 C.C.R 2505-10, Section 8.552

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 8.552 with the proposed text beginning at 8.552.2 through th end of 8.552.7.C. This rule is effective January 30, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning In-Home Support Services, Section 8.552
Rule Number: MSB 21-06-09-A
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STATEMENT OF BASIS AND PURPOSE

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

   Revision of In-Home Support Services (IHSS) Rule to strike language regarding the option for IHSS agencies to be a participant's Authorized Representative (AR) to align with current IHSS statue C.R.S. § 25.5-6-1202(2).

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021); and 25.5-6-1203, C.R.S. (2021)

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REGULATORY ANALYSIS

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

   Participants using In-Home Support Services (IHSS) under the Elderly, Blind and Disabled (EBD), Spinal Cord Injury (SCI), and Children's Home and Community Based Services (CHCBS) waivers that currently have IHSS agencies serving as their Authorized Representative (AR) will be affected by the proposed amendment. As of July 2021, the Department anticipates that this change impacts 289 members, 171 adults and 118 children, and 38 agencies who are actively serving as ARs for specific members.

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 current rules allow an IHSS Agency to act as an AR for a member they also provide services to. In addition to being a conflict of interest, this provision conflicts with the IHSS statute. The revision will prohibit IHSS Agencies from acting as a member's AR in alignment with the current statute. This change will impact 289 participants that have requested that their IHSS agency serve as their AR. Any individuals currently receiving AR services from their IHSS agency must transition from this by December 31, 2022.

   The impacted members will be required to find an appropriate AR not employed by their IHSS agency. If a member is not able to find an AR, they may need to explore a different service delivery option. The Department will provide additional training and support these members.

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.

DO NOT PUBLISH THIS PAGE

The Department does not anticipate any significant fiscal impact from this rule revision.

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

   If the Department does not revise this rule, the regulation will continue to contradict current state statute.

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

   The rule must align with statute. There is no exception in the statute that would permit an IHSS Agency to act as an AR.

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

   The Department does not have an alternative solution to removal of the contradictory language. However, the Department has worked collaboratively with stakeholder to improve the AR process, forms, and requirements to better ensure members have access to the services and supports they need.

8.552 IN-HOME SUPPORT SERVICES

8.552.1 DEFINITIONS

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

B. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS. A family member, including a spouse, may be an Attendant.

C. Authorized Representative means an individual designated by the client, or by the parent or guardian of the client, if appropriate, who has the judgment and ability to assist the client in acquiring and receiving services under Title 25.5, Article 6, Part 12, C.R.S. The authorized representative shall not be the eligible person's service provider.

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

E. Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6- 106, C.R.S., and has a current provider participation agreement with the Department.

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

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

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

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

J. Homemaker Services means general household activities provided by an Attendant in the client's primary living space 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.

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

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

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

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

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

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

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

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

8.552.2 ELIGIBILITY

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

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

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

3. Clients who elect or are required to have an Authorized Representative must appoint an Authorized Representative who has the judgment and ability to assist the client in acquiring and using services, ~~or~~

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

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

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

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

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

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

4. The client provides false information or false records.

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

8.552.3 COVERED SERVICES

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

8.552.3.B. Services available for eligible adults:

1. Homemaker

2. Personal Care

3. Health Maintenance Activities.

8.552.3.C. Services available for eligible children:

1. Health Maintenance Activities.

8.552.3.D. Service Inclusions:

1. Homemaker:

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

b. Meal preparation;

c. Dishwashing;

d. Bed making;

e. Laundry;

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

2. Personal Care:

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

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

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

   d. Bladder/Bowel Care:

      i) Assisting client to and from the bathroom;

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

      iii) Changing incontinence clothing or pads;

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

      v) Emptying ostomy bags;

      vi) Perineal care.

   e. Personal hygiene:

      i) Bathing including washing, shampooing;

      ii) Grooming;

      iii) Shaving with an electric or safety razor;

      iv) Combing and styling hair;

      v) Filing and soaking nails;

      vi) Basic oral hygiene and denture care.

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

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

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

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

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

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

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

k. Cleaning and basic maintenance of durable medical equipment.

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

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

3. Health Maintenance Activities:

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

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

i) Client is unable to complete task independently;

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

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

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

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

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

ii) In the presence of communicable disease;

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

iv) Oral suctioning is required;

v) There is decreased oral sensitivity or hypersensitivity;

vi) Client is at risk for choking and aspiration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   iii) The use of a mechanical lift is needed.

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

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

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

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

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

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

   ii) Care of external, indwelling and suprapubic catheters;

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

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

m. Respiratory care:

   i) Postural drainage

   ii) Cupping

   iii) Adjusting oxygen flow within established parameters

   iv) Suctioning of mouth and nose

   v) Nebulizers

   vi) Ventilator and tracheostomy care

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

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

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

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

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

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

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

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

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

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

ii) the client is unable to complete task independently.

8.552.4 CLIENT AND AUTHORIZED REPRESENTATIVE PARTICIPATION AND SELF-DIRECTION

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

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

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

3. Dismiss Attendants who are not meeting their needs.

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

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

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

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

8. Request a reassessment, as described at Section 8.393.2.D, if level of care or service needs have changed.

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

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

1. Must be at least 18 years of age.

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

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

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

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

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

8.552.5 IHSS AGENCY ELIGIBILITY

8.552.5.A. The IHSS Agency must be a licensed home care agency. The IHSS Agency shall be in compliance with all requirements of their certification and licensure, in addition to requirements outlined at Section 8.487.

8.552.5.B. The provider agreement for an IHSS Agency may be terminated, denied, or non-renewed pursuant to Section 8.076.5.

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

8.552.6 IHSS AGENCY RESPONSIBILITIES

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

1. Independent Living Core Services

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

2. Attendant training, oversight and supervision by a licensed health care professional.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.552.6.G. The IHSS Agency's Licensed Health Care Professional is responsible for the following activities:

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

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

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

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

5. Investigate complaints and critical incidents within ten (10) calendar days as defined in Section 8.487.15.

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

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

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

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

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

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

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

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

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

3. Instruction on basic first aid administration.

4. Instruction on safety and emergency procedures.

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

6. Mandatory reporting and critical incident reporting procedures.

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

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

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

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

2. May be a Family Member subject to the reimbursement and service limitations in Section 8.552.8.

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

4. Shall not, in exercising their duties as an IHSS Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse as defined in Section 25.5-6-1203, C.R.S.

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

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

8.552.7 CASE MANAGEMENT AGENCY RESPONSIBILITIES

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

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

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

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

2. The Shared Responsibilities Form shall be completed upon enrollment and following any change of condition. If the client requires an Authorized Representative, the ~~Authorized Representative Designation for In-Home Support Services (IHSS) form or In-Home Support Services (IHSS) Client and Provider Agency Responsibilities form~~Shared Responsibilities Form must include the designation and attestation of an Authorized Representative~~be completed~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Completing a reassessment if requested by the client as described at Section 8.393.2.D., if level of care or service needs have changed.

8.552.7.F. The Case Manager shall not authorize more than one consumer-directed program on the client's PAR.

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

8.552.7.H. Additional requirements for Case Managers:

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

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

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

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

   a. IHSS Care Plans;

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

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

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

8.552.7.I. Start of Services

1. Services may begin only after the requirements defined at Sections 8.552.2, 8.552.6.E., 8.552.6.I., and 8.552.7.C. have been met.

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

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

8.552.8 REIMBURSEMENT AND SERVICE LIMITATIONS

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

8.552.8.B. IHSS Personal Care services must comply with the rules for reimbursement set forth at Section 8.489.50. IHSS Homemaker services must comply with the rules for reimbursement set forth at Section 8.490.5.

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

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

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

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

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

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

c. The IHSS Agency shall not submit claims for Health Maintenance Activities when only Personal Care and/or Homemaking services are completed.

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

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

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

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

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

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

8.552.8.M. Independent Living Core Services, attendant training, and oversight or supervision provided by the IHSS Agency's Licensed Health Care Professional are not separately reimbursable. No additional compensation is allowable for IHSS Agencies for providing these services.

8.552.8.N. Travel time shall not be reimbursed.

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

8.552.9 DISCONTINUATION AND TERMINATION OF IN-HOME SUPPORT SERVICES

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

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

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

1. The client or their Authorized Representative fails to comply with IHSS program requirements as defined in Section 8.552.4, or

2. A client no longer meets program criteria, or

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

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

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

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

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

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

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

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Qualifications of Case Managers, Sections 8.393.1.J.; 8.519.5. and 8.603.9
Rule Number: MSB 21-11-17-A
Division / Contact / Phone: Office of Community Living / Victor Robertson / 303-866-6463

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 21-11-17-A, Revision to the Medical Assistance Rule concerning Qualifications of Case Managers, Sections 8.393.1.J.; 8.519.5. and 8.603.9

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)8.393.1.J.; 8.519.5.; 8.603.9, 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 8.393.1.J with the proposed text beginning at 8.393.1.J.1 through the end of 8.393.1.J.3. Replace the current text at 8.519.5 with the proposed text beginning at 8.519.5 through the end of 8.519.5.B. Replace the current text at 8.603.9 with the proposed text beginning at 8.603.9.E through the end of 8.603.9.E. This rule is effective January 30, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Qualifications of Case Managers, Sections 8.393.1.J.; 8.519.5. and 8.603.9
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STATEMENT OF BASIS AND PURPOSE

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

   The rules at 8.393.1.J.; 8.519.5.; 8.603.9 outline the education and experience qualifications for case managers in the SEP, HCBS and CCB systems. Currently there is a workforce shortage impacting the system and the department is requesting changes to the qualifications to allow for more avenues to qualify as a case manager, hoping to increase the pool of candidates.

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021); Section 25.5-10-209.5, C.R.S.

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Qualifications of Case Managers, Sections 8.393.1.J.; 8.519.5. and 8.603.9
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REGULATORY ANALYSIS

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

   This proposed rule will affect state Medicaid providers, including Community Centered Boards, Single Entry Points and CHCBS Case Management Providers. There is no cost associated with the proposed rule. Providers and members will benefit from an improved workforce resulting from promulgation of these rules.

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

   The proposed rule will likely improve the ability for case management agencies to hire case managers. It is difficult to quantify the impact; however, the rules have incorporated input from stakeholders to remove barriers to recruiting qualified candidates.

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 anticipated costs associated with the proposed rules. The rules remove the requirement to request a waiver from the department, so there will be less administrative burden to the Case Management Agencies and the Department.

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

   There is possible cost of case managers being less qualified and the benefit of a larger candidate pool if the rule is adopted. The costs of inaction are members waiting for assessment/enrollment for services needed to assure health and safety, high caseloads resulting in poor quality of case management services, including monitoring for health and safety, support plan development, and service utilization. There are no identified benefits of inaction.

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

   No other methods have been identified.

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 other alternatives were considered; this is the method proposed by the stakeholders.

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.J. Qualifications of Staff

1. The SEP ~~Agency's supervisor(s) and~~ case manager(s) hired on or after ~~September 10, 2021~~October 8, 2021 shall meet minimum standards for HCBS case managers required in Section~~10 CCR 2505-10~~ 8.519.5.B ~~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 Agency 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 Agency 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 Agency shall request a written waiver 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 be kept in the case manager's personnel file.~~

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

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

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

   ~~iii~~c. Interviewing and assessment skills;

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

   ~~v~~e. Ability to develop Support Plans and service agreements;

   ~~vi~~f. Knowledge of LTSS and other community resources; and

   ~~vii~~g. Negotiation, intervention and interpersonal communication skills.

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

8.519 Case Management

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.~~8.519.5.B.~~ minimum qualifications for HCBS Case Managers hired on or after ~~September 10~~October 8th, 2021 are~~is~~:

1. A bachelor's degree; or
2. Five (5) years of relevant experience in the field of LTSS, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.
4. Relevant experience is defined as:

a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and,

b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.

~~1. A bachelor's degree from an accredited college or university in human services, nursing, psychology, sociology, behavior science, social work, special education, gerontology, public health or non-profit administration; or~~
~~2. A bachelor's degree and a minimum of one (1) year of relevant work experience; or~~
~~3. Four (4) years of combined relevant work experience and education in human services, nursing, psychology, sociology, behavior science, social work, special education, gerontology, public health or non-profit administration, where 30 semester and 45 quarter credits equals one year; or,~~
~~4. Five (5) years of relevant work experience.~~
~~5. Relevant work experience is defined as:~~

~~a. Paid work experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and,~~

~~b. Completed coursework and/or paid work experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant work experience.~~

~~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 IMS Documentation

14. Mandatory Reporting

15. Participant Directed Training

16. Disability and Cultural Competency

17. Any Case Management training required by contract

8.519.5.F. Case Managers must demonstrate and document competency in the following areas:

1. Knowledge and experience working with populations served by the Case Management Agency;

2. Knowledge of the statutes, regulations, policies and procedures regarding public assistance programs and the American with Disabilities Act;

3. Knowledge of LTSS and other community resources;

4. Negotiation, conflict resolution, intervention, cultural and linguistic training, disability cultural competency, and interpersonal communication skills; and

5. Knowledge of consumer direction philosophy and programs.

8.519.5.G. Case Managers shall attend any mandatory training required by the Department.

8.519.5.H. Case Manager supervisors shall meet the minimum requirements for education and/or experience for Case Managers and shall have one year of competency in pertinent case management knowledge and skills.

8.519.5.I. Background checks.

1. Prior to employment, all case management staff must have the following minimal background checks and screenings:

a. Criminal;

b. Medicaid or other federal health programs exclusion list;

c. Sex offender registry; and

d. Adult protective services data system.

2. Background checks must be repeated at minimum every five (5) years with the exception of the adult protective services data system.

3. Proof of checks and screenings must be maintained and made available.

8.603 PROGRAM APPROVAL BY THE DEPARTMENT

8.603.9 PERSONNEL AND CONTRACTOR ADMINISTRATION

A. Community centered boards and program approved service agencies shall establish qualifications for employees and contractors (Host Home and other providers) and maintain records documenting the qualifications and training of employees and contractors who provide services pursuant to these rules and regulations.

B. The community centered board or service agency may, in accordance with section 27-90-110, C.R.S., conduct background checks and reference checks prior to employing staff providing supports and services and contracting with Host Home and other providers.

C. The community centered board in its role as support coordinating agency, as defined in section 8.609.1, shall have screening procedures for individual providers who are not agency employees and for other entities providing services and supports.

D. The community centered board and program approved service agency shall have an organized program of orientation and training of sufficient scope for employees and contractors to carry out their duties and responsibilities efficiently, effectively and competently. The program shall, at a minimum, provide for:

1. Extent and type of training to be provided prior to employees or contractors providing supports and services having unsupervised contact with persons receiving services;

2. Training related to health, safety and services and supports to be provided within the first ninety (90) days for employees and contractors; and,

3. Training specific to the individual(s) for whom the employees or contractors will be providing services and supports.

E. Community centered boards shall ensure that individuals who are hired to fulfill the duties of case management services on or after ~~September 10~~October 8, 2021 meet the requirements in Section ~~10 CCR 2505 10~~ 8.519.5.B. ~~have at least a bachelor's level degree of education, five (5) years of experience in the field of developmental disabilities, or some combination of education and experience appropriate to the requirements of the position.~~

F. All employees and contractors, not otherwise authorized by law to administer medication, who assist and/or monitor persons receiving services in the administration of medications or the filling of medication reminder systems shall have passed a competency evaluation offered by an approved training entity, as defined in 6 CCR 1011-1, Chapter 24, *et seq*.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements, Sections 8.520.8, 8.540.2 and 8.540.7
Rule Number: MSB 21-11-17-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-11-17-B, Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements

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) 8.520.8, 8.540.2 and 8.540.7, 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 8.520 with the proposed text beginning at 8.520.8.C through the end of 8.520.8.C. Replace the current text at 8.540 with the proposed text beginning at 8.540.2.A through the end of 8.540.2.A. Replace the current text at 8.540.7 with the proposed text beginning at 8.540.7 through the end of 8.540.7. This rule is effective January 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements, Sections 8.520.8, 8.540.2 and 8.540.7
Rule Number: MSB 21-11-17-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   Update the long-term home health and private duty nursing rules to resume prior authorization on a tiered schedule over the course of ten months.

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements, Sections 8.520.8, 8.540.2 and 8.540.7
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REGULATORY ANALYSIS

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

   Members receiving pediatric long-term home health and private duty nursing, and the providers rendering such services, will be affected by the proposed rule. Providers will bear the cost of submitting prior authorization requests for these services.

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

   Providers of pediatric long-term home health and private duty nursing will be required to submit prior authorization requests to continue, or initiate new, services. Prior authorization review will determine whether such services will be covered under Health First Colorado (Colorado Medicaid) moving forward.

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.

   Implementing and enforcing this rule change could result in a reduction in Medicaid spending on pediatric long-term home health and private duty nursing over time if services authorized through the prior authorization requests are lower than current utilization. The Department anticipates that expenditure will remain in line with historical utilization trends as the suspension of the prior authorization requirements was temporary.

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

   The probable costs of the proposed rule are implementing prior authorization requirements for pediatric long-term home health and private duty nursing. The probable benefit of the proposed rule is bringing Department practice in line with the Colorado State Plan. The probable cost of inaction is misalignment between

Department rule and the Colorado State Plan. There are no probable benefits to inaction.

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

   There are no less costly or intrusive methods to align Department rule with the Colorado State Plan.

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.

8.520 HOME HEALTH SERVICES

8.520.8 Prior Authorization

8.520.8.A. General Requirements

1. Approval of the PAR does not guarantee payment by Medicaid.

2. The client and the HHA shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations.

3. Medicaid is always the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to only bill for Medicaid approved services to Medicare or other third party insurance prior to billing Medicaid.

    a. Exceptions to this include Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP) and the following services that are not a skilled Medicare benefit (CNA services only, OT services only, Med-box pre-pouring and routine lab draws).

8.520.8.B. Acute Home Health

1. Acute Home Health Services do not require prior authorization. This includes episodes of acute home health for long-term home health clients.

2. If a client receiving long-term Home Health Services experiences an acute care event that necessitates moving the client to an acute home health episode, the agency shall notify the Department or its Designee that the client is moving from long-term home health to acute Home Health Services.

3. If the client's acute home health needs resolve prior to 60 calendar days, the Home Health Agency shall discharge the client, or submit a PAR for long-term Home Health Services if the client is eligible.

    a. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 9 calendar days or less, the Home Health Agency shall resume the client's care under the current acute home health Plan of Care.

    b. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 10 calendar days or more, the Home Health Agency may start a new Acute Home Health episode when the client returns to the Home Health Agency.

    c. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within 10 working days of the beginning and within 10 working days of the end of the acute care episode.

8.520.8.C. Long-Term Home Health

1. Beginning November 1, 2021, ~~L~~providers must submit a prior authorization request (PAR) for all new long-term pediatric Home Health Services ~~do not require prior authorization~~ under Section 8.017.E. For members currently receiving long-term pediatric Home Health Services initiated prior to November 1, 2021, providers must submit a PAR in accordance with the following schedule:

   1. Ten percent (10%) of PARs must be submitted by November 30, 2021;

   2. An additional 10% of PARs must be submitted by December 31, 2021;

   3. An additional 10% of PARs must be submitted by January 31, 2022;

   4. An additional 10% of PARs must be submitted by February 28, 2022;

   5. An additional 10% of PARs must be submitted by March 31, 2022;

   6. An additional 10% of PARs must be submitted by April 30, 2022;

   7. An additional 10% of PARs must be submitted by May 31, 2022;

   8. An additional 10% of PARs must be submitted by June 30, 2022;

   9. An additional 10% of PARs must be submitted by July 31, 2022;

   ~~1.~~10. The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.

2. When an agency accepts an HCBS waiver client to long-term Home Health Services, the Home Health Agency shall contact the client's case management agency to inform the case manager of the client's need for Home Health Services.

3. The complete formal written PAR shall include:

   a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;

   b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services;

   c. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance;

d. Any other medical information which will document the medical necessity for the Home Health Services;

e. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;

f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the client's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and

g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.

h. Long Term Home Health Services for clients 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.

4. Authorization time frames:

a. PARs shall be submitted for, and may be approved for up to a one year period.

b. The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.

c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the CMS-485.

5. The PAR shall not be backdated to a date prior to the 'from' date of the CMS-485.

6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding clients:

a. PAR Approval: If services requested are in compliance with Medicaid rules are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (e.g, the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.

ii) When denied or reduced, services shall be approved for ~~15~~ 60 additional days after the date on which the notice of denial is mailed to the client.

through August 31, 2022. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

c. Interim Services: Services provided during the period between the provider's submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.

8.520.8.D. EPSDT Services

1. Home Health Services beyond those allowed in Section 8.520.5, for clients ages 0 through 20, shall be reviewed for medical necessity under the EPSDT requirement, as defined at Section 8.280.1.

2. Home Health Services beyond those in Section 8.520.5, which are provided under the Home Health benefit due to medical necessity, cannot include services that are available under other Colorado Medicaid benefits for which the client is eligible, including, but not limited to, Private Duty Nursing, Section 8.540; HCBS Personal Care, Section 8.489; Pediatric Personal Care, Section 8.535; School Health and Related Services, Section 8.290, or Outpatient Therapies, Section 8.200.3.A.6, Section 8.200.5 and Section 8.200.3.D Exceptions may be made if EPSDT Home Health Services will be more cost-effective, provided that client safety is assured. Such exceptions shall, in no way, be construed as mandating the delegation of nursing tasks.

3. PARs for EPSDT home health shall be submitted and reviewed as outlined in Section 8.520.8, including all documentation outlined in Section 8.520.8, and any other medical information which will document the medical necessity for the EPSDT Home Health Services. The Plan of Care shall include the place of service for each home health visit.

8.520.8.E. Home Health Telehealth Services

1. Home Health Telehealth services require prior authorization.

2. The Home Health Telehealth PAR shall include all of the following:

   a. A completed enrollment form;

   b. An order for telehealth monitoring signed and dated by the Ordering Practitioner or podiatrist;

   c. A Plan of Care, which includes nursing and therapy assessments for clients. Telehealth monitoring shall be included on the CMS-485 form, or a form that contains identical information to the CMS-485, and all applicable forms shall be complete; and

   d. For ongoing telehealth, the agency shall include documentation on how telehealth data has been used to manage the client's care, if the client has been using Home Health Telehealth services.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.2 BENEFITS

8.540.2.A. Beginning November 1, 2021, providers must submit a prior authorization request for all new PDN services ~~do not require prior authorization~~. For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request in accordance with the schedule provided in Section 8.540.7.G.

8.540.2.B. A pediatric client may be approved for up to 24 hours per day of PDN services if the client meets the URC medical necessity criteria. PDN for pediatric clients is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable.

1. The URC shall determine the number of appropriate pediatric PDN hours by considering age, stability, need for frequent suctioning and the ability to manage the tracheostomy.

2. The URC shall consult with the Home Health Agency and the attending physician or primary care physician, to provide medical case management with the goal of resolving the problem that precipitated the need for extended PDN care of more than 16 hours.

3. The URC shall consider combinations of technologies and co-morbidities when making medical criteria determinations.

8.540.2.C. Twenty-four hour care may be approved for pediatric clients during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year.

8.540.2.D. Adult clients may be approved for up to 16 hours of PDN per day.

8.540.2.E. A client who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the client's activities of daily living take him or her away from the home. The total hours authorized shall not exceed the hours that would have been authorized if the client received all care in the home.

8.540.7 PRIOR AUTHORIZATION PROCEDURES

8.540.7.A. The Home Health Agency shall submit the initial PAR to the URC prior to the start of PDN.

8.540.7.B. The PAR shall be approved for up to six months for a new client and up to one year for ongoing care depending upon prognosis for improvement or recovery, according to the medical criteria.

8.540.7.C. The PAR information shall:

1. Be submitted on a Department PAR form. A copy of the current plan of care shall be included. For new clients admitted to PDN directly from the hospital, a copy of the transcribed verbal physician orders may be substituted for the plan of care if the client has been approved for admission to PDN.

2. Be submitted with the plan of care that:

    a. Is on the CMS 485 form, or a form that is identical in format to the CMS 485. All sections of the form relating to nursing needs shall be completed.

    b. Includes a signed nursing assessment, a current clinical summary or update of the client's condition and a physician's plan of treatment. A hospital discharge summary shall be included if there was a hospitalization since the last PAR.

    c. Indicates the frequency and the number of times per day that all technology-related care is to be administered. Ranges and a typical number of hours needed per day are required. The top of the range is the number of hours ordered by the physician as medically necessary. The lower number is the amount of care that may occur due to family availability or choice, holidays or vacations or absence from the home.

    d. Includes a process by which the client receiving services and support may continue to receive necessary care, which may include respite care, if the client's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or the caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.

3. Include an explanation for the decision to use an LPN. This decision shall be at the discretion of the attending physician, the Home Health Agency and the RN responsible for supervising the LPN.

4. Cover a period of up to one year depending upon medical necessity determination.

5. Include only the services of PDN-RN and/or PDN-LPN. If any other services are included on the PAR, the URC shall return the PAR without processing it.

6. Be submitted within five working days of the change as a revision when a change in the plan of care results in an increase in hours. A revised plan of care or a copy of the physician's verbal orders for the increased hours including the effective date shall be included with the PAR form.

7. Be submitted to decrease the number of hours for which the client may be eligible when a change in the client's condition occurs which could affect the client's eligibility for PDN, or decrease the number of hours for which the client may be eligible. The agency shall

notify the URC within one working day of the change. Failure to notify the URC may result in recovery of inappropriate payments, if any, from the Home Health Agency.

8. Be submitted within five working days of the discharge or death, as a revised PAR when a client is discharged or dies prior to the end date of the PAR. The revision is to the end date and the number of service units.

8.540.7.D. The URC shall review PARs according to the following procedures:

1. Review information provided and apply the medical criteria as described herein.

2. Return an incomplete PAR to the Home Health Agency for correction within ~~seven~~ ten working days of receipt.

3. Approve the PAR, or refer the PAR to the URC physician reviewer, within 10 working days of receipt of the complete PAR.

4. Process physician review referrals and approve, partially approve, or deny the PAR within 10 working days of receipt from the nurse reviewer. The URC physician reviewer shall attempt to contact the attending physician or the primary care physician for more information prior to a denial or reduction in services.

5. Provide written notification to the client or client's designated representative and submitting party of all PAR denials and the client's appeal rights, within one working day of the decision.

6. Approve subsequent continued stay PARs that have been to physician review without referral, if the client's condition and the requested hours have not changed.

7. Notify the Department of all extraordinary PDN services approved as a result of an EPSDT screen.

8. Notify the submitting party of all PAR approvals.

9. Expedite PAR reviews in situations where adhering to the time frames above would seriously jeopardize the client's life or health.

8.540.7.E. No services shall be approved for dates of service prior to the date the URC receives a complete PAR. PAR revisions for medically necessary increased services may be approved back to the day prior to receipt by the URC if the revised PAR was received within five working days of the increase in services. Facsimiles may be accepted.

8.540.7.F. The URC nurse reviewer may attend hospital discharge planning conferences, and may conduct on site visits to each client at admission and every six months thereafter.

8.540.7.G. ~~Claims for O~~For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request (PAR) in accordance with the schedule in Sections 8.540.7.G.1-10. When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client.

1. Ten percent (10%) of PARs must be submitted by November 30, 2021;

2. An additional 10% of PARs must be submitted by December 31, 2021;

3. An additional 10% of PARs must be submitted by January 31, 2022;

4. An additional 10% of PARs must be submitted by February 28, 2022;

5. An additional 10% of PARs must be submitted by March 31, 2022;

6. An additional 10% of PARs must be submitted by April 30, 2022;

7. An additional 10% of PARs must be submitted by May 31, 2022;

8. An additional 10% of PARs must be submitted by June 30, 2022;

9. An additional 10% of PARs must be submitted by July 31, 2022;

~~1.~~10. The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.