DO NOT PUBLISH THIS PAGE

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

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

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

3. This action is an adoption of: new rules

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

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

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

PUBLICATION INSTRUCTIONS*

Insert the proposed text at 8.519.27. Use the proposed text beginning at 8.519.27.A through the end of 8.519.27.G. Replace the current text at 8.763 with the proposed text beginning at 8.763 through th end of 8.763.C. This rule is effective January 1, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

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

STATEMENT OF BASIS AND PURPOSE

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

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

2. An emergency rule-making is imperatively necessary

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

   Explain:

   HB18-1326 directs the Department to put transitions services in place by January 1, 2019 because the last day new members can enroll under the demonstration project is December 31, 2018. An emergency rule is needed both to comply with the legislation and to avoid a gap in services for the preservation of public health, safety and welfare of members who are transitioning to community based living.

3. Federal authority for the Rule, if any:

   42 CFR § 441.18

   The federal authority for this is implemented per the Colorado Medicaid State Plan, pending federal approval of the State Plan Amendment.

4. State Authority for the Rule:

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

   CRS 25.5.-10-209.5 and CRS 25.5-6-106

Initial Review
Proposed Effective Date **01/01/19**
Final Adoption
Emergency Adoption **12/14/18**

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

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

REGULATORY ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.519.27 Transition Coordination Services

8.519.27.A Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.519.27.B Qualifications of agencies offering transition services

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

Have a physical location in Colorado

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

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

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

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

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

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

Demonstrate ability to meet all state and federal requirements governing the participation of transition coordination agencies in the state Medicaid program, including but not limited to the ability to meet state and federal requirements for documentation, billing, and auditing

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

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

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

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

8.519.27.C Functions of all Transition Coordination Agencies

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

Transition coordination agencies shall be responsible to maintain sufficient documentation of all transition coordination activities performed and to support claims.

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

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

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

Transition coordination agencies shall provide services in accordance with state business days.

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

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

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

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

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

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

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

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

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

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

1. Assessment of community needs and risk factors.

2. Transition planning and risk mitigation planning.

3. Referral and coordination for non-Medicaid transition-related services and supports.

4. Monitoring and transition plan review.

5. Denial and discontinuation of transition coordination.

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

8.519.27.D Qualifications of Transition Coordinators

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

Transition coordinator minimum experience:

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

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

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

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

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

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

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

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

c. Be financially responsible for the client.

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

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

8.519.27.E Training

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

1. Community needs and risk factor assessment.

2. Risk mitigation plan development, monitoring and revision.

3. Referral for non-Medicaid services.

4. Transition plan development, monitoring and revision.

5. Case documentation.

6. Person-centered approaches to planning and practice.

7. Housing voucher application and housing navigation services.

8.519.27.F Functions of transition coordinators

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

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

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

b. Participate in the development of a risk mitigation plan to address identified risk factors.

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

d. Identify and conduct referrals for non-Medicaid services

e. Determine if the identified necessary supports and services are available at the frequency needed.

f. Participate in a team decision regarding feasibility of transition.

g. Facilitate completion of a transition plan if transition is determined to be feasible.

2. Pre-transition coordination includes:

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

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

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

d. Assist client to create a transition budget.

e. Facilitate a community-based living arrangement.

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

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

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

3. Post-transition monitoring includes:

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

b. Respond to risk incidents and notify case manager.

c. Revise risk mitigation plan as needed.

d. Assess need for life skills training.

e. Problem-solve community integration issues.

f. Support community integration activities.

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

h. Complete client satisfaction survey to evaluate the client's experience of following:

i. Service planning.

ii. Transition plan implementation.

iii. Transition coordination process.

iv. Level and adequacy of services and referrals provided.

v. Overall client satisfaction.

4. Post-transition monitoring shall occur at the frequency and type to meet the client's community risk level, but no less than the following:

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

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

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

ii. Face-to face in community.

iii. By telephone or electronic communication.

5. Post-transition monitoring may not duplicate services for Life Skills Training (LST), defined in 10 CCR 2505-10, § 8.553.3; Transition Setup10 CCR 2505-10, § 8.553.4; Home Delivered Meals, defined in 10 CCR 2505-10, § 8.553.4; and Peer Mentorship, defined in 10 CCR 2505-10, § 8.553.5; and Transition Setup10 CCR 2505-10, § 8.553.6.

8.519.27.G Conflict of Interest for Transition Coordination Agencies

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

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

8.760 TARGETED CASE MANAGEMENT SERVICES

8.763 TARGETED CASE MANAGEMENT - TRANSITION COORDINATION

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

8.763.A Eligibility

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

8.763.B Services

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

8.763.C Limitations on Service

Pending federal approval, transition coordination is limited to 240 units per client per transition. When an individual has a documented need for additional units, the 240 unit cap may be exceeded in cases of medical necessity. The Transition Coordinator shall submit documentation to the Department including:

1. Copy of the community risk assessment describing the client's current needs
2. The number of additional units requested
3. History of transition coordination units provided to date and outcomes of those services
4. Explanation of the additional transition coordination supports to be provided by the transition coordinator using any additional approved units

DO NOT PUBLISH THIS PAGE

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

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

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

   Sections(s) 8.485, 8.500.5, 8.500.90, 8.509, 8.515, 8.517, 8.516, and 8.553, Colorado Department of Health Care Policy and Financing, Child Health Plan *Plus* (10 CCR 2505-3).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	1/1/2019
Is rule to be made permanent? (If yes, please attach notice of hearing).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.485.30 with the proposed text beginning at 8.485.31 through the end of 8.485.32. Replace the current text at 8.485.40 with the proposed text beginning at 8.485.40 through the end of 8.485.40. Replace the current text at 8.500.94 with the proposed text beginning at 8.500.94.A through the end of 8.500.94.C. Replace the current text at 8.509.12 with the proposed text beginning at 8.509.12 through the end of 8.509.13. Replace the current text at 8.515 with the proposed text beginning at 8.515.2.A through the end of 8.515.2.B. Replace the current text at 8.516.10.D with the proposed text beginning at 8.516.10.D through the end of

*to be completed by MSB Board Coordinator

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8.516.10.D. Replace the current text at 8.517 with the proposed text beginning at 8.517.1.A through the end of 8.517.1.B. Replace the current text at 8.553 with the proposed text beginning at 8.553 through the end of 8.553.6. This rule is effective January 1, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

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

STATEMENT OF BASIS AND PURPOSE

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

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

2. An emergency rule-making is imperatively necessary

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

   Explain:

   An emergency rule will avoid a gap in these services for individuals who have expressed or will express interest in transitioning to the community or who need supports to remain in the community during a change in life circumstance.

3. Federal authority for the Rule, if any:

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

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

Initial Review
Proposed Effective Date **01/01/19**
Final Adoption
Emergency Adoption **12/14/18**

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

4. State Authority for the Rule:

   Section 25.5-1-301 through 25.5-1-303, C.R.S. (2017)" and Section 25.5-6-1501, C.R.S.

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REGULATORY ANALYSIS

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

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

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

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

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

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

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

The Department of Health Care Policy & Financing (the Department) has administered the Colorado Choice Transitions (CCT) demonstration program since April 2013,

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

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

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

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

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

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

The CCT program has demonstrated that, as of, December 2017, 328 Health First Colorado members transitioned into the community at a savings of more than $2.8 million to the state of Colorado. CMS has determined that services provided in

institutional settings have proven costlier than those provided in the community; as mentioned, this determination has been corroborated by the CCT program's findings.

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

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

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

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

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

The Department has not yet established Medicaid administrative claiming. CMS allows for services such as those proposed in 8.553 to be reimbursed through a Medicaid administrative claiming prior to the transition occurring. Administrative claiming may be a vehicle, on its own, to fund and house services or the administrative claiming may work in conjunction with transition services otherwise housed in waivers. In the latter case, the administrative claiming could provide reimbursement for the proposed Transition Setup services furnished prior to a client's enrolling in a waiver through the services would thereafter be reimbursed. Without the administrative fund, the State is

limited to reimbursing providers for transition setup services furnished only upon a client's enrollment in the respective waiver.

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

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

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

...

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

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

A. Adult day services; and

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

C. Consumer Directed Attendant Support Services; and

D. Electronic monitoring; and

E. Home Delivered Meals; and

F. Home modification; and

G. Homemaker services; and

H. In-Home Support Services; and

I. Non-medical transportation; and

J. Peer Mentorship; and

K. Personal care; and

L. Respite care; and

M. ~~Transition Independent Living~~Life Skills Training; and

N. Transition Setup.

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

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

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

A. Adult day services shall be as defined at 10 CCR 2505-10, § 8.491.

B. Alternative Care Facility ~~services~~Services shall be as defined at 10 CCR 2505-10, § 8.495.

C. Consumer Directed Attendant Support Services (CDASS) shall be defined at 10 CCR 2505-10, § 8.510.

D. Electronic monitoring services shall be as defined at 10 CCR 2505-10, § 8.488.

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

F. Home modification shall be as defined at 10 CCR 2505-10, § 8.493.

G. Homemaker services shall be as defined at 10 CCR 2505-10, § 8.490.

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

I. Non-medical transportation services shall be as defined at 10 CCR 2505-10, § 8.494.

J. Peer Mentorship services shall be defined at 10 CCR 2505-10, § 8.553.

K. Personal care services shall be as defined at 10 CCR 2505-10, § 8.489.

L. Respite care shall be as defined at 10 CCR 2505-10, § 8.492.

M. ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST) services shall be as defined at 10 CCR 2505-10, § 8.553.

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

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

8.500.5 HCBS-DD WAIVER SERVICES

8.500.5.A. SERVICES PROVIDED

1. Behavioral Services
2. Day Habilitation Services and Supports
3. Dental Services
4. Home Delivered Meals
5. Non-Medical Transportation
6. Peer Mentorship
7. Residential Habilitation Services and Supports (RHSS)
8. Specialized Medical Equipment and Supplies
9. Supported Employment
10. Transition Setup
11. Vision Services

8.500.5.B. DEFINITIONS OF SERVICES

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

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

   …

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

   …

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

   …

4. Home Delivered Meals as defined at 10 CCR 2505-10, § 8.553.

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

   …

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

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

   …

8. Specialized Medical Equipment and Supplies include:

   …

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

   …

10. Transition Setup services as defined at 10 CCR 2505-10, § 8.553.

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

    …

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

…

8.500.94 HCBS-SLS WAIVER SERVICES

8.500.94.A. SERVICES PROVIDED

1. Assistive Technology
2. Behavioral Services
3. Day Habilitation services and supports
4. Dental Services
5. Health Maintenance
6. Home Accessibility Adaptations
7. Home Delivered Meals
8. Homemaker Services
9. Mentorship
10. Non-Medical Transportation
11. Peer Mentorship
12. Personal Care
13. Personal Emergency Response System (PERS)
14. Professional Services, defined below in 8.500.94.B.
15. Respite

16. Specialized Medical Equipment and Supplies

17. Supported Employment

18. Vehicle Modifications

19. Vision Services

20. ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST)

21. Transition Setup

8.500.94.B. DEFINITIONS OF SERVICES

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

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

   …

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

   …

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

   …

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

   …

~~5.~~ ~~HEALTH MAINTENANCE ACTIVITIES ARE AVAILABLE ONLY AS A PARTICIPANT DIRECTED SUPPORTED LIVING SERVICE IN ACCORDANCE WITH 8.500.94.C. HEALTH MAINTENANCE ACTIVITIES MEANS ROUTINE AND REPETITIVE HEALTH RELATED TASKS FURNISHED TO AN ELIGIBLE CLIENT IN THE COMMUNITY OR IN THE CLIENT'S HOME, WHICH ARE NECESSARY FOR HEALTH AND NORMAL BODILY FUNCTIONING THAT A PERSON WITH A DISABILITY IS UNABLE TO PHYSICALLY CARRY OUT. SERVICES MAY INCLUDE:~~

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

   …

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

   …

7. Home Delivered Meals as defined at 10 CCR 2505-10, § 8.553.

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

   …

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

   a. Assistance in interviewing potential providers,

   b. Assistance in understanding complicated health and safety issues,

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

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

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

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

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

   h. Mentorship services are distinct from Peer Mentorship services, which are defined at 10 CCR 2505-10, § 8.553.

   …

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

    …

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

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

    …

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

    …

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

    …

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

    …

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

    …

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

    …

18. ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST) as defined at 10 CCR 2505-10, § 8.553.

19. Transition Setup as defined at 10 CCR 2505-10, § 8.553.

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

    …

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

    …

~~**8.500.94.C. PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES**~~

~~Participant direction of HCBS-SLS waiver services is authorized pursuant to the provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293 and § 25.5-6-1101, et seq., C.R.S. (2018).~~

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

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

~~i) Personal Care as defined at 10 CCR 2505-10, § 8.500.94.B.12.~~

~~ii) Homemaker as defined at 10 CCR 2505-10, § 8.500.94.B.8.~~

~~iii) Health Maintenance Activities as defined at 10 CCR 2505-10, § 8.500.94.B.5.~~

~~3. The case manager shall conduct the case management functions SET FORTH at 10 CCR 2505-10, § 8.510.14 et. seq.~~

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

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

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

~~1. Adult Day Services~~

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

~~3. Consumer Directed Attendant Support Services (CDASS)~~

~~4. Electronic Monitoring~~

~~5. Home Delivered Meals~~

~~6. Home Modification~~

~~7. Homemaker Services~~

~~8. Non-Medical Transportation~~

~~9. Peer Mentorship~~

~~10. Personal Care~~

~~11. Respite Care~~

8.500.94.C. PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES

Participant direction of HCBS-SLS waiver services is authorized pursuant to the provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293 and § 25.5-6-1101, et seq., C.R.S. (2018).

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

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

   i) Personal Care as defined at 10 CCR 2505-10, § 8.500.94.B.12.

   ii) Homemaker as defined at 10 CCR 2505-10, § 8.500.94.B.8.

   iii) Health Maintenance Activities as defined at 10 CCR 2505-10, § 8.500.94.B.5.

3. The case manager shall conduct the case management functions SET FORTH at 10 CCR 2505-10, § 8.510.14 et. seq.

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

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

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

1. Adult Day Services

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

3. Consumer Directed Attendant Support Services (CDASS)

4. Electronic Monitoring

5. Home Delivered Meals

6. Home Modification

7. Homemaker Services

8. Non-Medical Transportation

9. Peer Mentorship~~Transition Independent Living~~

10. Personal Care

11. Respite Care

12. Life Skills Training (~~T-ILST~~LST)

13. Transition Setup

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

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

8.509.13 DEFINITIONS OF SERVICES

A. Adult Day Services is defined at 10 CCR 2505-10, § 8.491, ADULT DAY SERVICES.

B. Alternative Care Facility Services is defined at 10 CCR 2505-10, § 8.495, ALTERNATIVE CARE FACILITY.

C. Consumer Directed Attendant Support Services (CDASS) is defined at 10 CCR 2505-10, § 8.510, CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES.

D. Electronic Monitoring services is defined at 10 CCR 2505-10, § 8.488, ELECTRONIC MONITORING.

E. Home Delivered Meals is defined at 10 CCR 2505-10, § 8.553, HOME DELIVERED MEALS.

F. Home Modification is defined at 10 CCR 2505-10, § 8.493, HOME MODIFICATION.

G. Homemaker Services is defined at 10 CCR 2505-10, § 8.490, HOMEMAKER SERVICES.

H. Non-Medical Transportation is defined at 10 CCR 2505-10, § 8.494, NON-MEDICAL TRANSPORTATION.

I. Peer Mentorship is defined at 10 CCR 2505-10, § 8.553, PEER MENTORSHIP.

J. Personal Care is defined at 10 CCR 2505-10, § 8.489, PERSONAL CARE.

K. Respite is defined at 10 CCR 2505-10, § 8.492, RESPITE CARE.

L. ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST) is defined at 10 CCR 2505-10, § 8.553. ~~TRANSITION INDEPENDENT LIVING~~LIFE SKILLS TRAINING.

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

…

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

…

8.515.2 HCBS-BI WAIVER SERVICES

8.515.2.A SERVICES PROVIDED

1. Adult Day Services
2. Behavioral Programming and Education
3. Consumer Directed Attendant Support Services (CDASS)
4. Counseling Services
5. Day Treatment
6. Electronic Monitoring Services
7. Home Delivered Meals
8. Home Modification
9. Independent Living Skills Training (ILST)
10. Non-Medical Transportation Services
11. Peer Mentorship
12. Personal Care
13. Respite Care
14. Specialized Medical Equipment and Supplies
15. Substance Abuse Counseling
16. Supported Living

Transition Setup

17.

18. Transitional Living Program

8.515.2.B DEFINITIONS OF SERVICES

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

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

~~...~~

~~**8.515.2 HCBS-BI WAIVER SERVICES**~~

~~**8.515.2.A SERVICES PROVIDED**~~

~~1. Adult Day Services~~

~~2. Behavioral Programming and Education~~

~~3. Consumer Directed Attendant Support Services (CDASS)~~

~~4. Counseling Services~~

~~5. Day Treatment~~

~~6. Electronic Monitoring Services~~

~~7. Home Delivered Meals~~

~~8. Home Modification~~

~~9. Independent Living Skills Training (ILST)~~

~~10. Non-Medical Transportation Services~~

~~11. Peer Mentorship~~

~~12. Personal Care~~

~~13. Respite Care~~

~~14. Specialized Medical Equipment and Supplies~~

~~15. Substance Abuse Counseling~~

~~16. Supported Living~~

~~17. Transition Setup~~

~~18. Transitional Living Program~~

~~8.515.2.B DEFINITIONS OF SERVICES~~

~~1. Adult Day Services means services as defined at 10 CCR 2505-10, § 8.515.70~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

…

8.516.10 INDEPENDENT LIVING SKILLS TRAINING

…

D. REIMBURSEMENT

1. Reimbursement shall be on a 15 minute basis. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as independent living services. The time billed for travel shall be listed separately from the time for service provision on each visit but must be documented on the same form. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period.

8.517 HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY WAIVER

8.517.1 HCBS-SCI WAIVER SERVICES

8.517.1.A SERVICES PROVIDED

1. Adult Day Services
2. Complementary and Integrative Health Services
3. Consumer Directed Attendant Support Services (CDASS)
4. Electronic Monitoring
5. Home Delivered Meals
6. Home Modification
7. Homemaker Services
8. In-Home Support Services
9. Non-Medical Transportation
10. Peer Mentorship
11. Personal Care Services
12. Respite Care
13. ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST)
14. Transition Setup

8.517.1.B DEFINITIONS OF SERVICES

1. Adult Day Services means services as defined at 10 CCR 2505-10, § 8.491.
2. Complementary and Integrative Health Services means services as defined at 10 CCR 2505-10, § 8.517.~~11.~~
3. Consumer Directed Attendant Support Services (CDASS) means services as defined at 10 CCR 2505-10, § 8.510.
4. Electronic Monitoring means services as defined at 10 CCR 2505-10, § 8.488.
5. Home Delivered Meals means services as defined at 10 CCR 2505-10, § 8.553.
6. Home Modification means services as defined at 10 CCR 2505-10, § 8.493.
7. Homemaker Services means services as defined at 10 CCR 2505-10, § 8.490.
8. In-Home Support Services means services as defined at 10 CCR 2505-10, § 8.552.
9. Non-Medical Transportation means services as defined at 10 CCR 2505-10, § 8.494.
10. Peer Mentorship means services as defined at 10 CCR 2505-10, § 8.553.
11. Personal Care Services means services as defined at 10 CCR 2505-10, § 8.489.

12. Respite Care means services as defined at 10 CCR 2505-10, § 8.492.

13. ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST) means services as defined at 10 CCR 2505-10, § 8.553.

14. Transition Setup means services as defined at 10 CCR 2505-10, § 8.553.

8.553 HOME DELIVERED MEALS, LIFE SKILLS TRAINING, PEER MENTORSHIP, & TRANSITION SETUP SERVICES

8.553.1 GENERAL DEFINITIONS

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

Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the ~~state department~~Department to provide case management services for Home and Community Based Services ~~Waivers~~waivers pursuant to ~~§~~sections 25.5~~-~~.~~-~~10-209.5 and CRS 25.5-6-106, C.R.S~~. (2018). The case management agency shall provide case management services~~, and pursuant to a provider participation agreement with the state department.

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

Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

Home and Community Based Services (HCBS) Waivers means services and supports provided through a waiver authorized in § 1915(c) of the Social Security Act, 42 U.S.C. § 1396n(c) and provided in community settings to a client who requires an institutional level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

Home Delivered Meals means nutritional counseling, planning, preparation, and delivery of meals to clients who have dietary restrictions or specific nutritional needs, are unable to prepare their own meals, and have limited or no outside assistance.

Institutional Setting: Institutions or institution-like settings, including a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Regional Center or Home and Community Based Setting that is operated by the state.

Life Skills Training (LST) means individualized training designed and directed with the client to develop and maintain their ability to independently sustain themselves—physically, emotionally, socially and economically—in the community. LST may be provided in the client's residence, in the community, or in a group living situation.

Life Skills Training (LST) program service plans are plans designed and inclusive of the services that will be provided as part of the LST service, to include scope, frequency, and duration, that meet the need of the client in their ability to independently sustain himself/herself physically, emotionally, socially, and economically in the community. This plan is developed with the client and the provider.

Nutritional Meal Plan is a plan consisting of the complete nutritional regimen that the Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) recommends to the individual for overall health and wellness, and shall include additional recommendations outside of the Medicaid-authorized meals for additional nutritional support and education.

Peer Mentorship means support provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world experiences as examples, and modeling successful community living and problem-solving.

~~Regional Center means a facility or program operated directly by the Department, which provides services and supports to persons with developmental disabilities.~~

~~Risk factors means factors that include but are not limited to health, safety, environmental, community acclimation challenges, interruption of service provision, lack of support systems and substance abuse that may contribute to an individual's community risk level.~~

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

~~Risk mitigation planning means the process of identifying risk factors, developing options and actions to enhance opportunities and prevent risk factors from occurring and actions to respond to the occurrence of a risk factor.~~

Service Plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the department rules.

~~1. Targeted Case Management - Transition Services (TCM-TS) means support provided to a client who is transitioning from a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center and includes the following activities: comprehensive assessment for transition, development and periodic revision of a service plan, referral and related activities, and monitoring and follow up activities.~~

~~Transition Assessment means assessing the individual's transition needs and preferences for community living to include the need for medical, social, cultural, educational, behavioral and other services. Assessment will also include the identification of risk factors related to living in the community, the development of a risk mitigation plan, identification of needed supports to address needs, preferences, and risk factors and determine the feasibility of transition based on availability of necessary supports and services.~~

~~Transition Independent Living Skills Training (T-ILST) means individualized training designed and directed with the client to develop and maintain their ability to independently sustain themselves—physically, emotionally, socially and economically—in the community. T-ILST may be provided in the client's residence, in the community, or in a group living situation.~~

~~Transition Independent Living Skills Training (T-ILST) program service plans are plans designed and inclusive of the services that will be provided as part of the T-ILST service, to include scope, frequency, and duration, that meet the need of the client in their ability to independently sustain himself/herself physically, emotionally, socially, and economically in the community. This plan is developed with the client and the provider.~~

~~Transition Independent Living Skills Training (T-ILST) Trainers means individuals who directly support the client through Transition Independent living Skills Training (T-ILST), including designing with the client individualized T-ILST program service plans and implementing the plans through training with the client to develop and maintain their ability to independently sustain themselves—physically, emotionally, socially and economically—in the community.~~

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

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

~~Transition Services means services to support a successful transition from a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to a Home and Community Based Setting that is not operated by the state.~~

Transition Setup Authorization Request Form is a formal document delineating and requesting the authorization of payment for the items and/or services required for the transition set up to occur. This document is submitted to the Case Management Agency.

Transition Setup means coordination and coverage ~~for~~of one-time, non-recurring expenses necessary for a member to establish a basic household ~~as they transition~~upon transitioning from a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to ~~establish an independent~~a community living arrangement~~.~~ that is not operated by the state.

8.553.2~~8.553.2~~ SERVICE ACCESS AND AUTHORIZATION

~~A. A person accessing Transition Services must:~~

~~1. Have resided in a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or Regional Center for a period of 90 days. Days of a rehab stay will not count towards the 90 days.~~

~~2. Be willing to participate and have expressed an interest in moving to a Home and Community Based setting; and~~

~~3. Have or obtain Medicaid eligibility prior to discharging from the nursing facility, ICF/IID, or Regional Center setting and prior to accessing Transition Services needed to assist the person with planning and preparing for the transition; and~~

~~4. Work with the Case Management Agency to:~~

~~a. Select the services needed for a successful transition through the eligible HCBS Waivers; and~~

~~b. Obtain authorization of the HCBS services in accordance with the Transition Plan developed by the Transition Options Team (TOT) in accordance with the Department's rule at 10 CCR 2505-10, § 8.519; and~~

Life

~~c. Transition to a Home and Community Based Services setting that complies with federal and state rules.~~

~~B. Unless specified otherwise, Transition Services are available, based on need, up to 365 days post-transition.~~

~~C. Services available include:~~

A. ~~Transition Independent Living~~ Skills Training (~~T-ILST) as~~ defined in 10 CCR 2505-10, § 8.553.3~~.~~, must be an assessed need, documented in Service Plan, for which the client demonstrates the following:

1. Establishment of specific community supports where they may not otherwise exist; or

2. The Member would be at risk of homelessness without these services; or

3. The need demonstrates risk to health or safety or a risk of moving to a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center; and

4. Following an absence from the community.

5. Services may not be authorized beyond 365 days from initial service provision.

a. Exceptions will be granted based on extraordinary circumstances.

B. To access a specific Service, the client must demonstrate a need by meeting the respective service's additional criteria, Services and their respective additional criteria are:

1. Life Skills Training (LST), defined in 10 CCR 2505-10, § 8.553.3~~.~~, must be an assessed need, documented in Service Plan, for which the client demonstrates the following:

~~T-ILST Is~~`~

a. The client demonstrates a need for training designed and directed with the member to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community;

b. The client identifies skills for which training is needed and demonstrates that without the skills, the client risks their health, safety, or ability to live in the community;

c. The client demonstrates that without training they could not develop the skills needed;

d. The client demonstrates that with training they have ability to acquire these skills or services necessary within 365 days.

~~a.~~ LST is available in the ~~following HCBS Waivers:~~

~~2.~~

e. Department's HCBS-CMHS Waiver under the Department's rule at 10 CCR 2505-10, § 8.509.12~~;~~, HCBS-EBD Waiver under 10 CCR 2505-10, § 8.485.30;

HCBS-SCI Waiver under 10 CCR 2505-10, § 8.517.1; and HCBS-SLS Waiver under 10 CCR 2505-10, § 8.500.94.

To access Home Delivered Meals,

3.2. ~~Transition Setup as~~ defined in 10 CCR 2505-10, § 8.553.4~~.~~, the client must participate in a needs assessment through which they demonstrate a need for the service based on the following:

a. ~~Transition Setup~~The client demonstrates a need for nutritional counseling, meal planning, and preparation;

b. The client can show documented special dietary restrictions or specific nutritional needs;

c. The client has limited or no outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;

d. The client cannot prepare meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;

e. The client's inability to access and prepare nutritious meals demonstrates a need related risk to health, safety, or institutionalization; and

f. The assessed need is documented in the client's Service Plan as part of their acquisition process of gradually becoming capable of preparing their own meals or establishing the resources to obtain their needed meals.

~~a.~~ Home Delivered Meals is available in the ~~following HCBS Waivers:~~
~~b.~~

~~c.~~g. Department's HCBS-BI Waiver under the Department's rule 10 CCR 2505-10, § 8.515.2; HCBS-CMHS Waiver under the Department's rule 10 CCR 2505-10, § 8.509.12; HCBS-DD Waiver under 10 CCR 2505-10, § 8.500.5; HCBS-EBD Waiver under 10 CCR 2505-10, § 8.485.30; HCBS-SCI Waiver under 10 CCR 2505-10, § 8.517.1; and HCBS-SLS Waiver under 10 CCR 2505-10, § 8.500.94.

4. ~~Home Delivered Meals as~~To access Peer Mentorship, defined in 10 CCR 2505-10, § 8.553.5~~.~~

, a client must participate

5.3 .~~Home Delivered Meals is available~~ in a needs assessment through which they demonstrate the need for the service based on the following ~~HCBS Waivers:~~:

~~i) HCBS-BI Waiver under the Department's rule 10 CCR 2505-10, § 8.515.2; HCBS-CMHS Waiver under the Department's rule 10 CCR 2505-10, § 8.509.12; HCBS-DD Waiver under 10 CCR 2505-10, § 8.500.5; HCBS-EBD Waiver under 10 CCR 2505-10, § 8.485.30; HCBS-SCI Waiver under 10 CCR 2505-10, § 8.517.1; and HCBS-SLS Waiver under 10 CCR 2505-10, § 8.500.94.~~

a. To access Peer Mentorship, a client must demonstrate a need for soft skills, insight, or guidance from a peer.

b. The client must demonstrate that without this service they may experience a health, safety, or institutional risk; and

c. There are no other services or resources available to meet the need.

~~6. Peer Mentorship as defined in 10 CCR 2505-10, § 8.553.6.~~

~~a.~~ Peer Mentorship is available in the ~~following HCBS Waivers:~~

~~b.~~d. Department's HCBS-BI Waiver under the Department's rule 10 CCR 2505-10, § 8.515.2; HCBS-CMHS Waiver under the Department's rule 10 CCR 2505-10, § 8.509.12; HCBS-~~DD Waiver under 10 CCR 2505-10, § 8.500.5; HCBS-~~EBD Waiver under 10 CCR 2505-10, § 8.485.30; HCBS-SCI Waiver under 10 CCR 2505-10, § 8.517.1; HCBS-DD Waiver under 10 CCR 2505-10, § 8.500.5; and HCBS-SLS Waiver under 10 CCR 2505-10, § 8.500.94.

8.553.3 ~~TRANSITION INDEPENDENT LIVING~~LIFE SKILLS TRAINING (~~T-ILST~~LST)

A. INCLUSIONS

1. ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST) includes assessment, training, maintenance, supervision, assistance, or continued supports of the following skills ~~training~~:

a. Problem-solving ~~transition-related issues~~;

b. ~~Training~~Identifying and ~~guidance on how to independently identify and access~~accessing mental and behavioral health services;

~~c. Training on developing and establishing sustained self-care skills, including but not limited to basic personal hygiene;~~

c. Self-care and activities of daily living;

d. Medication reminders and supervision, not to include medication administration;

e. Household management;

f. Time management ~~skills training~~;

g. Safety awareness ~~skill development and training~~;

h. Task completion ~~skill development and training~~;

i. Communication skill building;

j. Interpersonal skill development;

k. Socialization, including but not limited to acquiring and developing skills that promote healthy relationships, assistance with understanding social norms and values, and support with acclimating to the community;

l. Recreation, including leisure and community engagement;

m. Assistance with understanding and following plans for occupational or sensory skill development;

n. ~~Training and guidance on how to independently access resource~~Accessing resources and benefit coordination, including activities related to coordination of community transportation, community meetings, community resources, housing resources, activities related to the coordination of Medicaid services, and other available public and private resources;

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

p. ~~Skills training may include training for~~Acquiring and utilizing assistive technology when appropriate and not duplicative of training covered under other ~~waiver~~ services.

2. All ~~Transition Independent Living~~Life Skills Training shall be documented in the ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST) program service plans. Reimbursement is limited to services described in the ~~Transition Independent Living~~Life Skills Training (~~T-ILST~~LST) program service plans.

B. LIMITATIONS AND EXCLUSIONS

1. Clients may utilize ~~T-ILST~~LST up to 24 units (six hours) a day, for no more than 160 units (40 hours) a week, up to 365 days ~~post-transition~~following the first day the service is provided.

2. ~~T-ILST~~LST is not to be delivered simultaneously during the direct provision of Adult Day Health, Adult Day Services, Group Behavioral Counseling, Consumer Directed Attendant Support Services (CDASS), Health Maintenance Activities, Homemaker, In Home Support Services (IHSS), Mentorship, Peer Mentorship, Personal Care, Prevocational Services, Respite, Specialized Habilitation, Supported Community Connections, or Supported Employment.

   a. ~~T-ILST~~LST can be provided with Non-Medical Transportation (NMT) when the person providing NMT is different than the person providing ~~T-ILST~~LST to the client.

   b. ~~T-ILST~~LST may be delivered during the provision of Behavioral Line Staff only when directly authorized by the Department of Health Care Policy and Financing.

3. ~~T-ILST~~LST does not include services offered under the State Plan or other resources.

4. ~~T-ILST~~LST does not include services offered through other waiver services, except those that are incidental to the ~~T-ILST~~LST training activities or purposes or are incidentally provided to ensure the client's health and safety during the provision of ~~T-ILST~~LST.

C. PROVIDER ~~STANDARDS~~QUALIFICATIONS

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

~~a. The provider must have a Home Care Agency Class A or B license from the Colorado Department of Public Health and Environment (CDPHE); and must be recommended by CDPHE to the Department for certification as a T-ILST provider; or~~

~~b.~~

~~c. The provider may furnish T-ILST services through December 31, 2019, without Home Care Agency Class A or B licensure and recommendation for T-ILST certification from CDPHE if the provider, prior to December 31, 2018, has enrolled in and furnished and billed Independent Living Skills Training services through the Colorado Choice Transitions (CCT), a Money Follows the Person demonstration, found in the Department's rule at 10 CCR 2505-10, § 8.555. On or after July 1, 2019, an existing provider shall not manage and offer, directly or by contract, T-ILST services or operate or maintain a T-ILST Agency without having submitted a completed application for Class A or B licensure to CDPHE.~~

~~2.~~

~~3. A provider providing services to clients through the HCBS-CMHS, -EBD, or -SCI waivers~~ A provider furnishing services to waiver clients shall abide by all general certification standards, conditions, and processes established for the client's respective waiver: HCBS-CMHS, -EBD, or -SCI waivers in the Department's rule at 10 CCR 2505-10, § 8.487; HCBS-SLS waiver ~~shall abide by all general certification standards, conditions, and processes established~~ in the Department's rule at 10 CCR 2505-10, § 8.500.98.~~and~~

~~4.~~1. ~~A provider furnishing services to clients throughshall abide by all general certification standards, conditions, and processes established ; and~~

5.2. In accordance with 42 C.F.R § 441.301(c)(1)(vi), the ~~T-ILST~~LST provider, or those who have an interest in or are employed by the provider, must not be of the same provider or agency that ~~determines the client's eligibility,~~ authorizes ~~the service to the client,~~services or ~~that~~ develops the client's Service Plan with the client; and

6.3. Agencies must employ ~~a T-ILST~~an LST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training ~~and~~or a degree within a relevant field; and

~~7. The coordinator~~Agencies must ~~review the client's T-ILST program service plan to~~ ensure ~~it is designed and directed at meeting the need of the client in their ability to independently sustain themselves physically, emotionally, and economically in the community; and~~

~~8. The coordinator must share the T-ILST program service plan with the client's providers of other HCBS services that support or implement~~ any ~~service inclusions of the client's T-ILST program that meet the need of the client in their ability to independently sustain himself/herself physically, emotionally, and economically in the community. This plan is developed with the client and the provider. The T-ILST coordinator will seek permission from the client prior to sharing in entirety or portions of the T-ILST program service plan with other providers; and~~

4. ~~Any~~ component of the ~~ILST~~LST plan that may contain activities outside the scope of the ~~ILST~~LST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the client.

a. The professional must be licensed in good standing in the ~~relevant~~ scope of practice appropriate to meet the client's LST need as relevant to one of the following:

i) Occupational Therapist;

ii) Physical Therapist;

iii) Registered Nurse;

iv) Speech Language Pathologist;

v) Psychologist;

vi) Neuropsychologist;

vii) Medical Doctor;

viii) Licensed Clinical Social Worker

ix) Licensed Professional Counselor; or

x) Board Certified Behavior Analyst (BCBA)

b. ~~Professionals~~ An appropriately licensed professional providing ~~components~~a component(s) of the ~~T-ILST~~LST plan can ~~include individuals who are~~be an agency staff~~, contracted~~ member, contract staff member, or external ~~licensed~~ professional; and ~~certified professionals who are~~

~~b.~~c. The appropriately licensed professional must be fully aware of duties conducted by ~~T-ILST~~LST trainers; ~~and~~

~~9. All T-ILST service plans containing any professional activity must be reviewed and authorized monthly over the transition service period, or as needed, by professionals responsible for oversight as referenced above.~~

~~10. T-ILST Trainer~~

5. ~~T-ILST~~The agency must employ one or more LST Trainers to directly support clients, one-on-one, through designing with the client individualized LST program service plans and implementing the plans through training with the client.

a. LST trainers must meet one of the following education, experience, or certification requirements:

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

ii) Individuals with a Bachelor's degree and ~~one~~1 year of experience working with individuals with disabilities; or

iii) Individuals with an Associate's degree in a social service or human relations area and ~~two~~2 years of experience working with individuals with disabilities; or

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

v) Individuals with 4 years direct care experience teaching or working with needs of individuals with disabilities ~~in a home setting, hospital setting, or rehabilitation setting~~.

vi) Individuals with 4 years of lived experience transferable to training designed and directed with the member to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community; and the provider must ensure that this individual receives member-specific training sufficient to enable the individual to competently provide LST to the client consistent with the LST Plan and the overall Service Plan.

b. The agency shall administer a series of training programs to all ~~T-ILST~~LST trainers~~.~~:

c. Prior to delivery of and reimbursement for any services, ~~T-ILST~~LST trainers must complete the following trainings:

i) Person-centered support approaches; and

ii) HIPAA and client confidentiality; and

iii) Basics of working with the population to be served; and

iv) On-the-job coaching by an incumbent ~~T-ILST~~LST trainer; and

v) Basic safety and de-escalation techniques; and

vi) Training on community and public resource availability; and

vii) Recognizing emergencies and knowledge of emergency procedures including basic first aid, home and fire safety.

viii) ~~T-ILST~~For trainers qualified through Individuals with 4 years of lived experience transferable to supporting a member in training designed and directed with the member to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community, the provider must ensure that the trainer receives additional member-specific training sufficient to enable the individual to

competently provide LST to the client consistent with the LST Plan and the overall Service Plan.

d. LST trainers must also receive ongoing training, required within 90 days of unsupervised contact and annually, in the following areas:

i) Cultural awareness; and

ii) Updates on working with the population to be served; and

iii) Updates on resource availability.

e. ~~T-ILST~~LST trainers or those interfacing with the client must undergo a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed or contracted by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider.

D. PROVIDER RESPONSIBILITIIES

1. Life Skills Training (LST) Trainers directly support the client through designing with the client individualized LST program service plans and implementing the plans through training with the client to develop and maintain their ability to independently sustain themselves—physically, emotionally, socially and economically—in the community.

2. The LST coordinator must review the client's LST program service plan to ensure it is designed and directed at meeting the need of the client in their ability to independently sustain themselves physically, emotionally, and economically in the community; and

3. The LST coordinator must share the LST program service plan with the client's providers of other HCBS services that support or implement any service inclusions of the client's LST program that meet the need of the client in their ability to independently sustain himself/herself physically, emotionally, and economically in the community. This plan is developed with the client and the provider. The LST coordinator will seek permission from the client prior to sharing in entirety or portions of the LST program service plan with other providers; and

4. Any component of the LST plan that may contain activities outside the scope of the LST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the client. The professional must be fully aware of duties conducted by LST trainers.

5. All LST service plans containing any professional activity must be reviewed and authorized monthly over the service period, or as needed, by professionals responsible for oversight as referenced above.

~~D.~~E. DOCUMENTATION

1. All ~~T-ILST~~LST providers must maintain a ~~T-ILST~~LST program service plan that includes:

a. Monthly skills training plans to be developed and documented; and

b. Skills training plans that include goals, goals met or not met, and progress made towards accomplishment of ongoing goals.

c. All documentation, including but not limited to, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to 10 CCR 2505-10, § 8.130 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request, including:

i) Start and end time/duration of service provision; and

ii) Nature and extent of service; and

iii) Description of ~~T-ILST~~LST activities such as accompanying clients to complicated medical appointments or to attend board, advisory and commissions meetings, and support provided interviewing potential providers; and

iv) Progress toward Service Plan goals and objectives; and

v) Provider's signature and date.

2. The ~~T-ILST~~LST program service plan shall be sent to the Case Management Agency responsible for the Service Plan on a monthly basis, or as requested by the Case Management Agency.

3. The ~~T-ILST~~LST program service plan shall be shared with the client's providers of other HCBS services that support or implement any service inclusions of the client's ~~T-ILST~~LST program that meet the need of the client in their ability to independently sustain himself/herself physically, emotionally, socially, and economically in the community.

4. If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Training and Documentation Standards for Personal Care.

~~E.~~F. REIMBURSEMENT

1. ~~T-ILST~~LST is billed in 15 minute units. Clients may utilize ~~T-ILST~~LST up to 24 units (six hours) a day, no more than 160 units (40 hours) a week, up to 365 days ~~post-transition~~following the first day the service is provided.

2. Payment for ~~T-ILST~~LST shall be the lower of the billed charges or the maximum rate of reimbursement.

3. ~~T-ILST~~LST may be furnished to escort clients if it is incidental to performing a ~~T-ILST~~LST service in the service definition. However, any transportation costs beyond accompaniment may not be billed ~~T-ILST~~LST services. ~~T-ILST~~LST providers may furnish and bill separately for transportation, provided that they meet the state's provider qualifications for transportation services, whether medical transportation under the State plan or non-medical transportation under the waiver.

4. If provided through the same agency, the person providing transportation and billing Non-Medical Transportation (NMT) must be different than the person providing ~~T-ILST~~LST to the client.

5. Personal Care or Homemaker may be furnished within the scope of ~~T-ILST~~LST in order to assist a person to train on a skill (e.g. assisting a client with mobility as a support necessary for the client to train on a particular skill); or as an adjunct to the provision of training (e.g. training a client toward a household management goal(s) by performing a homemaker tasks for the purposes of demonstrating technique or steps toward completion); however, the ~~T-ILST~~LST provider's incidental, adjunct provision of such services is not to be billed as the provision of a distinct additional service. Incidental services are factored into the rate and are accordingly intrinsic to claims for ~~T-ILST~~LST service provision.

8.553.4 ~~TRANSITION SETUP~~

~~A. INCLUSIONS~~

~~1. Transition Setup includes two components: Transition Setup Coordination and Transition Setup Expense.~~

~~a. Transition Setup Coordination assists the client with assessing needed items or services to transition, coordinating the purchasing or service required to meet that need, and to ensure the home environment is ready for move-in with all applicable furnishings set-up and functionally operable; and~~

~~2. Transition Setup Expense covers the purchase of one-time, non-recurring expenses necessary for a client to establish a basic household as they transition from a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center for to establish an independent living arrangement. Set Allowable expenses include:~~

~~a. Security deposits that are required to obtain a lease on an apartment or home.~~

~~b. Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).~~

~~c. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.~~

~~d. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.~~

~~i) A one-time purchase of basic pantry essentials not to exceed $250.~~

~~ii) A one-time purchase of necessary personal effects that enable a person to transition to and sustain a community based setting, not to exceed $150.~~

~~e. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.~~

~~f. Housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal background check.~~

D. ~~LIMITATIONS AND EXCLUSIONS~~

2. ~~Clients may utilize Transition Setup one-time purchase up to 30 days post-transition and with a maximum limit of $1,500. The Department may authorize additional funds above the $1500 unit limit, not to exceed a total value of $2,000, when it is demonstrated as a necessary expense to ensure the health, safety and welfare of the client.~~

3. ~~Clients may utilize Transition Setup Coordination services up to 30 days post-transition and with a maximum of 40 units; one unit equals 15-minutes.~~

4. ~~Clients must first utilize services available under the Medicaid State Plan, other waiver services, or other resources.~~

5. ~~Transition Setup services are not available when a transition occurs to a provider-owned or leased setting where the provider receives a room and board payment in addition to reimbursement for residential services.~~

2.

6. ~~Expenses for living arrangement settings are excluded that do not match or exceed HUD certification criteria.~~

3.

7. ~~Household appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television or video equipment, cable or satellite service, computers or tablets) are excluded.~~

E. ~~PROVIDER STANDARDS~~

4. ~~A provider enrolled with Colorado Medicaid is eligible to provide Transition Setup services if:~~

a. ~~A provider providing services to clients through the HCBS-CMHS, EBD, or SCI waivers shall abide by all general certification standards, conditions, and processes established in the Department's rule at 10 CCR 2505-10, § 8.487; and~~

b.

c. ~~A provider providing services to clients through the HCBS-DD waiver shall abide by all general certification standards, conditions, and processes established in the Department's rule at 10 CCR 2505-10, § 8.500.9; and~~

d.

e. ~~A provider providing services to clients through the HCBS-SLS waiver shall abide by all general certification standards, conditions, and processes established in the Department's rule at 10 CCR 2505-10, § 8.500.98; and~~

f.

g. ~~The provider is a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado; and~~

h. The provider has a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; and

i.

j. In accord with 42 C.F.R § 441.301(c)(1)(vi), the Transition Setup provider, or those who have an interest in or are employed by the provider, must not be of the same provider or agency that provides case management to the client or that develops the client's Service Plan; and

5. The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

E. DOCUMENTATION

1. Rendering and subsequent payment for these services requires receipts for all services and/or items procured by the Provider and must be attached to the claim and noted on the Prior Authorization Request in the appropriate manner.

2. Providers must submit to the Case Management Agency the minimum documentation standards of the transition process, which include:

a. Transition Services Referral Form

b. Release of Information (confidentiality) Forms

c. Transition Setup Authorization Request Form

3. All purchases require receipts be provided to the client to demonstrate the client's ownership.

F. REIMBURSEMENT

1. Transition Setup Coordination is billed in 15-minute unit increments. Coordination must not exceed 40 units per eligible client.

2. Transition Setup Expenses must not exceed of $1,500 per eligible client. The Department may authorize additional funds above the $1,500 limit, not to exceed a total value of $2,000, when it is demonstrated as a necessary expense to ensure the health, safety and welfare of the client.

3. Payment for Transition Setup shall be the lower of the billed charges or the maximum rate of reimbursement.

4. Reimbursement shall be made only for items or services described in the Service plan with an accompanying receipt.

5. When Transition Setup is furnished to individuals returning to the community from an institutional setting through entrance to the waiver, the costs of such services are incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver.

~~8.553.5~~ HOME DELIVERED MEALS

A. INCLUSIONS

Home Delivered Meals includes services available to clients who have dietary restrictions or specific nutritional needs, are unable to prepare their own meals, and have limited or no outside assistance; services include:

a. Individualized nutritional counselling and developing an individualized Nutritional Meal Plan, which specifies the client's nutritional needs, selected meal types, and instructions for meal preparation and delivery; and

b. Services to implement the individualized meal plan, specifically the client's specifications for preparing and delivering the identified nutritional meals to the client.

B. SERVICE ~~AUTHORIZATION~~REQUIREMENTS

1. Clients who access Home Delivered Meals must have dietary restrictions or specific nutritional needs, be unable to prepare their own meals, and have limited or no outside assistance.

2. The client's Service Plan, must indicate the assessed need for the Home Delivered Meal services, specifically the client's need for:

   a. Meeting with a certified Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) for individualized nutritional counselling and developing an individualized Nutritional Meal Plan, which specifies the client's nutritional needs, selected meal types, and instructions for meal preparation and delivery; and

   b. Services to implement the individualized meal plan, specifically the client's specifications for preparing and delivering the identified nutritional meals to the client.

3. The service is provided in the home or community and in accordance with the client's Service Plan. All Home Delivered Meal services shall be documented in the Service Plan.

4. Clients may utilize Home Delivered Meals over a period of 365 days ~~post-transition for the purposes of transitioning from a qualified nursing facility, ICF/IID, or Regional Center location to the community.~~following the first day the service is provided.

5. Meals are to be delivered up to two meals per day or 14 meals delivered one day per week.

6. Meals may include liquid, mechanical soft, or other medically necessary types.

7. Meals may be ethnically or culturally-tailored.

8. Meals may be delivered hot, cold, frozen, or shelf-stable depending on the ability of the client or caregiver, to complete the preparation of the meal and properly store them.

9. Delivery of Service shall be done in a face-to-face manner with the client, at home or in the community, in order for confirmation of meal reception and a wellness check in order to check whether the client is satisfied with the quality of the meal, and that the client receives the designated meal in a timely fashion.

10. The providing agency's certified RD or RDN will check-in quarterly with the client to ensure meals are satisfactory, promoting the client's health, and addressing their needs.

11. The RD or RDN will review client's progress towards any/all health and wellness goal(s) outlined in their Service Plan in conjunction with the Nutritional Meal Plan at least quarterly or more frequently as needed.

12. The RD or RDN will recommend any changes assessed on the Nutritional Meal Plan.

13. The RD or RDN will send the Nutritional Meal Plan to the Case Management Agency on a quarterly basis to inform the Case Management Agency's quarterly check-in with the client and corresponding updates to the Person-Centered Service plan as needed.

C. LIMITATIONS AND EXCLUSIONS

1. The unit designation for Home Delivered Meal services is per meal.

2. Reimbursement is limited to services described in the Service Plan.

3. Home Delivered Meals are not available ~~(to) an individual transitioning to the Residential Habilitation Services' Group Residential Services and Supports (GRSS) or Individual Residential Services and Supports – Host Home (IRSS-HH) and~~ when the person resides in a provider ~~agency receives room and board payment~~owned or controlled setting.

4. Delivery must not constitute a full nutritional regimen; and includes no more than two meals per day or 14 meals per week, over the 365-days ~~post-transition.~~following the first day the service is provided.

5. Excluded are items or services through which the client's need for Home Delivered Meal services can otherwise be met, including any item or service available under the State Plan, applicable HCBS waiver, or other resources.

6. Excluded are meals not identified in the Nutritional Meal Plan or any item outside of the meals not identified in the meal plan, such as additional food items or cooking appliances.

7. Meal plans and meals provided are only available for the benefit of the client.

D. PROVIDER STANDARDS

1. A licensed provider enrolled with Colorado Medicaid is eligible to provide Home Delivered Meal services if:

    a. The provider is a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado; and

    ~~b.~~ A~~The~~ provider ~~providing services to clients through the HCBS-CMHS, -EBD, or -SCI waivers shall abide by~~must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, or -SCI waivers in the Department's rule at 10 CCR 2505-10, § 8.487; ~~and~~

c. ~~A provider providing services to clients through the~~ HCBS-DD waiver ~~shall abide by all general certification standards, conditions, and processes established~~ in the Department's rule at 10 CCR 2505-10, § 8.500.9; ~~and~~

b. ~~A provider providing services to clients through the~~ HCBS-SLS waiver ~~shall abide by all general certification standards, conditions, and processes established~~ in the Department's rule at 10 CCR 2505-10, § 8.500.98; and

c. The provider shall have all licensures required by the State of Colorado Department of public health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff or, if otherwise applicable, in accordance with the City and County municipality in which this service is provided; and

d. Providers must have an on-staff or contracted Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN); and

e. In accord with 42 C.F.R § 441.301(c)(1)(vi), the Home Delivered Meals provider, or those who have an interest in or are employed by the provider, must not be of the same provider or agency that provides case management to the client or that develops the client's Service Plan with the client.

f. Staff providing direct services or those interfacing with the client must Staff providing direct services to the client must undergo a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed or contracted by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider.

E. DOCUMENTATION

1. The provider shall maintain documentation in accordance with 10 CCR 2505-10, § 8.130 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request. Required documentation includes:

   a. Documentation pertaining to the provider agency, including employee ~~files~~files, claim submission documents, program and financial records, insurance policies, and licenses, including a Retail Food License and Food Handling License for Staff, or, if otherwise applicable, documentation of compliance and good standing with the City and County municipality in which this service is provided; and

   b. Documentation pertaining to service provision, including:

      i) Signed authorization from appropriate licensed professional for dietary restrictions or specific nutritional needs; and

      ii) Consumer demographic information; and

      iii) Meal Delivery Schedule; and

      iv) Documentation of special diet requirements; and

v) Determination of the type of meal (e.g. hot, cold, frozen, shelf stable); and

vi) Date and place of service delivery; and

vii) Monitoring and follow-up (contacting the client to ensure the client is satisfied with the meal); and

viii) Provision of nutrition counseling.

F. REIMBURSEMENT

1. The unit designation for Home Delivered Meal services is per meal.

2. Payment for Home Delivered Meals shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the Service Plan.

8.553.~~6~~5 PEER MENTORSHIP

A. INCLUSIONS

1. Peer Mentorship~~-~~ means support provided by peers of the client on matters of community living, including:

a. Problem-solving ~~transition-related~~ issues drawing from shared experience.

b. Goal Setting, self-advocacy, community acclimation and integration techniques.

c. This service is ideally provided on a face-to-face basis, but mentorship can be provided in whichever medium is most suitable to both the mentee and mentor.

d. Assisting with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups and commissions.

e. Activities that promote interaction with friends and companions of choice.

f. Teaching and modeling of social skills, communication, group interaction, and collaboration.

g. Developing community client relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests.

h. Assisting the person in acquiring, retaining, and improving self-help, socialization, self-advocacy, and adaptive skills necessary for community living.

i. Support for integrated and meaningful engagement and awareness of opportunities for community involvement including volunteering, self-advocacy, education options, and other opportunities identified by the individual.

j. Assisting clients to be aware of and engage in community resources.

B. LIMITATIONS AND EXCLUSIONS

1. Services are limited to ~~24 units (six hours) per day,~~ up to 365-days ~~post-transition~~following the first day the service is provided.

2. Excluded are services covered under the State Plan, another waiver service, or by other resources

3. Excluded are services or activities that are solely diversional or recreational in nature.

C. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Peer Mentorship services if:

a. The provider is a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado; and

~~b. A~~The provider ~~providing services to clients through the HCBS-CMHS, -EBD, or -SCI waivers shall abide by~~must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, or -SCI waivers in the Department's rule at 10 CCR 2505-10, § 8.487; ~~and~~

~~c. A provider providing services to clients through the~~ HCBS-DD waiver ~~shall abide by all general certification standards, conditions, and processes established~~ in the Department's rule at 10 CCR 2505-10, § 8.500.9; ~~and~~

b. ~~A provider providing services to clients through the~~ HCBS-SLS waiver ~~shall abide by all general certification standards, conditions, and processes established~~ in the Department's rule at 10 CCR 2505-10, § 8.500.98; and

c. The provider has a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the provider's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; and

d. The provider must comply with CDPHE for compliance and complaint surveys.

e. In accord with 42 CFR 441.301(c)(1)(vi), the Peer Mentorship provider, or those who have an interest in or are employed by the provider, must not be of the same provider or agency that provides case management to the member, authorizes services for the member, or ~~that~~ develops the ~~member's Person-Centered Support~~client's Service Plan.

f. Peer Mentorship shall not be provided by a peer who receives programming from the same residential location, day program location, or employment location.

2. The provider must ensure services are delivered by a peer mentor staff who:

a. Has lived experience transferable to support a member with acclimating to community living through providing them member advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the member's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

~~a.~~b. Is qualified in the customized needs of the client as described in the Service Plan.

~~b.~~c. Has completed training from the provider agency consistent with ~~peer mentor competency~~core competencies and training standards presented to agencies by the Department at Peer Mentorship provider agency training. Core competencies are:

i) ~~Has~~Understanding of Boundaries;

ii) Goal Setting, and how to work towards it;

iii) Advocacy for Independence Mindset;

iv) Understanding of Disabilities, both visible and non-visible, and how they intersect with identity; and

v) Person-Centeredness

d. The Peer Mentor or those interfacing with the client undergone a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed or contracted by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider. Is not listed in state's Health Care Abuse Registry.

e. Is qualified in the customized needs of the client as described in the Service Plan.

f. Does not receive programming from the same residential location or day program location as the client.

~~6.~~3. The Agency employing a peer mentor must have a contingency plan identified in the client's Service Plan identifying how they will respond to an emergency issue, whether medical, behavioral or natural disaster, etc.

D. DOCUMENTATION

1. All documentation, including but not limited to, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to 10 CCR 2505-10, § 8.130 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request, including:

a. Start and end time/duration of service provision; and

b. Nature and extent of service; and

c. Mode of contact (face-to-face, telephone, other); and

d. Description of peer mentorship activities such as accompanying clients to complicated medical appointments or to attend board, advisory and commissions meetings, and support provided interviewing potential providers; and

e. Client's Response as outlined in the Peer Mentorship Manual; and

f. Progress toward Service Plan goals and objectives; and

g. Provider's signature and date.

E. REIMBURSEMENT

1. Peer Mentorship services billed in 15 minute units.

2. Payment for Peer Mentorship shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the Service Plan

8.553.5 TRANSITION SETUP

A. SERVICE ACCESS AND AUTHORIZATION

1. To access Transition Setup, defined in 10 CCR 2505-10, § 8.553.5, a client must be transitioning from an institutional setting to a community living arrangement and participate in a needs based assessment through which they demonstrate a need for the service based on the following:

a. The client demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a client to establish a basic household in the community;

b. The need demonstrates risk to the client's health, safety, or ability to live in the community.

c. Other services/resources to meet need are not available.

d. The client's assessed need must be documented in the client's Transition Plan and Service Plan.

e. Transition Setup is available the Department's HCBS-BI Waiver under the Department's rule 10 CCR 2505-10, § 8.515.2; HCBS-CMHS Waiver under the Department's rule 10 CCR 2505-10, § 8.509.12; HCBS-DD Waiver under 10 CCR 2505-10, § 8.500.5; HCBS-EBD Waiver under 10 CCR 2505-10, § 8.485.30; HCBS-SCI Waiver under 10 CCR 2505-10, § 8.517.1; and HCBS-SLS Waiver under 10 CCR 2505-10, § 8.500.94.

B. INCLUSIONS

1. Transition Setup assists the client coordinating the purchase of items or services needed to establish a basic household and to ensure the home environment is ready for move-in with all applicable furnishings set-up and functionally operable; and

2. Transition Setup covers the purchase of one-time, non-recurring expenses necessary for a client to establish a basic household as they transition from an institutional setting to a community setting. Allowable expenses include:

    a. Security deposits that are required to obtain a lease on an apartment or home.

    b. Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).

    c. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.

    d. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.

    e. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.

    f. Housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal background check.

C. LIMITATIONS AND EXCLUSIONS

1. Transition Setup may be used to coordinate or purchase one-time, non-recurring expenses up to 30 days post-transition.

2. Transition Setup coordination is billed in 15 minute unit increments. Transition Setup coordination is available up to 40 units per eligible member.

3. Transition Setup expenses must not exceed a total of $1,500 per eligible member. The Department may authorize additional funds above the $1,500 unit limit, not to exceed a total value of $2,000, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member.

4. Transition Setup does to substitute services available under the Medicaid State Plan, other waiver services, or other resources.

5. Transition Setup is not available for a transition to a living arrangement that is owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

6. Transition Setup does not include payment for room and board.

7. Transition Setup does not include rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes.

8. Transition Setup is not available for a transition to a living arrangement that does not match or exceed HUD certification criteria.

9. Transition Setup is not available when the person resides in a provider owned or controlled setting.

10. Transition Setup does not include appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television or video equipment, cable or satellite service, computers or tablets).

D. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Transition Setup services if:

   a. The provider is a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado; and

   b. The provider has a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; and

2. The provider must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, or -SCI waivers in the Department's rule at 10 CCR 2505-10, § 8.487; HCBS-DD waiver in the Department's rule at 10 CCR 2505-10, § 8.500.9; HCBS-SLS waiver in the Department's rule at 10 CCR 2505-10, § 8.500.98; and

3. In accord with 42 C.F.R § 441.301(c)(1)(vi), the Transition Setup provider, or those who have an interest in or are employed by the provider, must not be of the same provider or agency that provides case management to the client, authorizes services for the client, or develops the client's Service Plan with the client.

4. Staff providing direct services to the client must undergo a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider.

5. The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

E. DOCUMENTATION

1. Rendering and subsequent payment for these services requires receipts for all services and/or items procured by the Provider and must be attached to the claim and noted on the Prior Authorization Request in the appropriate manner.

2. Providers must submit to the Case Management Agency the minimum documentation standards of the transition process, which include:

a. Transition Services Referral Form

b. Release of Information (confidentiality) Forms

c. Transition Setup Authorization Request Form

3. All purchases require receipts be provided to the client to demonstrate the client's ownership.

F. REIMBURSEMENT

1. Transition Setup coordination is billed in 15-minute unit increments, and coordination must not exceed 40 units per eligible client.

2. Transition Setup expenses must not exceed of $1,500 per eligible client. The Department may authorize additional funds above the $1,500 limit, up to $2,000, when the client demonstrates an additional need for which the expense(s) would ensure the client's health, safety and welfare.

3. Payment for Transition Setup shall be the lower of the billed charges or the maximum rate of reimbursement.

4. Reimbursement shall be made only for items or services described in the Service plan with an accompanying receipt.

5. When Transition Setup is furnished to individuals returning to the community from an institutional setting through entrance to the waiver, the costs of such services are incurred and billable when the person leaves the institutional setting and enters the waiver.