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8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM

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

8.390.1 DEFINITIONS

A. Applicant means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in a Level of Care Eligibility Determination Screen.

C. Assessment means a comprehensive evaluation of an Applicant or Member, including but not limited to the individual's level of care, service needs, available resources, and potential funding resources using Department prescribed instrument(s), as required by the program for which they are applying or in which they are enrolled.

D. Case Management means the Assessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Person-Centered Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic Reassessment of such individual's needs.

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

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

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

HF. Failure to Satisfy the Scope of Work means acts or failures to act by the Single Entry Point Agency that constitute nonperformance or breach of the terms of its contract with the Department.

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

J. Home and Community Based Services (HCBS) waivers means services and supports authorized through a waiver under Section 1915(c) of the Social Security Act and provided in home- and community-based settings to individuals who require a level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

termediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

K. Information Management System (IMS) means an automated data management system prescribed by the Department to document case management activities and information for each individual seeking or receiving long-term and/or State General Fund services as well as to compile and generate standardized or custom summary reports.

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

~~lowing areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's need for financial and program assistance; and the need for an Assessment of the individual seeking services.~~

~~M. Level of Care Eligibility means an individual requires the level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities, as determined by the Department prescribed Level of Care Eligibility Determination Screen.~~

~~vel of Care Eligibility Determination Screen.~~

~~O. Level of Care Eligibility Determination means the outcome of the LOC Screen,~~

~~P. Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation of the Applicant or Member using a Department prescribed assessment instrument as outlined in section 8.401.~~

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

~~R. LTSS Program means any of the following: publicly funded programs, Home and Community-Based Services Elderly, Blind and Disabled Waiver (HCBS-EBD), Home and Community-Based Services Complementary and Integrative Health Waiver (HCBS-CIH), Home and Community-Based Services Brain Injury Waiver (HCBS-BI), Home and Community-Based Services Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community-Based Services Children with a Life Limiting Illness Waiver (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).~~

~~are, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).~~

~~S. Member means an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).~~

~~T. Person-Centered Support Planning means the process of collaborating with the individual receiving services and other people of their choosing to identify goals, needed services, individual choices and preferences, and service providers. This is based on Assessment and knowledge of the individual and of community resources and includes informing the individual of their rights and responsibilities.~~

~~and includes informing the individual of their rights and responsibilities.~~

~~U. Person-Centered Support Plan (PCSP) means the documentation of the Person-Centered Planning Process in the Department prescribed IMS using the Department prescribed format, including but not limited to the individual's chosen goals, services and providers.~~

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

~~appropriately, whether in the community or in a NF, and to ensure that individuals receive the services they require for their MI or ID.~~

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W. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to verify the individual's medical necessity for Long-Term Care Services.

X. Reassessment means a comprehensive reevaluation of an Applicant or Member, including but not limited to the individual's level of care, service needs, available resources, and potential funding resources using Department prescribed instrument(s), as required by the program for which they are applying or in which they are enrolled.

in which they are enrolled.

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

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

and referral to appropriate LTSS programs and case management services.

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

BB. Single Entry Point District means one or more counties that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of LTSS.

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

8.390.2 LEGAL AUTHORITY

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

8.390.3 CHARACTERISTICS OF INDIVIDUALS RECEIVING SERVICES IN LTSS PROGRAMS

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

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

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

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

ng LTSS in a nursing facility or through one of the HCBS Programs.

8.391 SINGLE ENTRY POINT DISTRICT DESIGNATION

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~~8.391.1.A. District Designation Requirements~~

~~Single Entry Point (SEP) districts shall meet the following requirements:~~

~~1. Counties composing a multi-county district shall be contiguous.~~

~~2. A single county may be designated a district provided the county serves a monthly average of 200 or more individuals for LTSS programs.~~

~~3. Multi-county districts shall not be required to serve a minimum number of individuals receiving services.~~

~~4. Each district shall assure adequate staffing and infrastructure by the district's SEP agency, including at least one full-time case manager employed by the SEP agency, to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.~~

~~8.391.1.B. Changes in Single Entry Point District Designation~~

~~1. In order to change SEP district designation, a county or district shall submit an application to the Department, six (6) months prior to commencement date of the proposed change. The application shall include the following information:~~

~~a. The geographic boundaries of the proposed SEP district;~~

~~b. Assurances that the proposed district meets all criteria set forth in Department rules for SEP district designation;~~

~~c. The designation of a contact person for the proposed district; and~~

~~d. A resolution supporting the application passed by the county commissioners of each county or parts of counties in the proposed district.~~

~~2. The application shall be approved provided the proposed district meets the SEP district designation requirements.~~

~~8.391.2 Single Entry Point Agency Selection~~

~~A. Except as otherwise provided herein, upon a change in SEP district designation or upon expiration of the district's existing SEP agency contract, a SEP district may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the SEP agency for the district. Once the SEP functions in a district are provided through a contract between the Department and an entity other than as listed above, the SEP agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.~~

~~ncy for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.~~

~~B. The agency selected by the SEP district shall serve as the SEP agency for the district unless the agency selected by the district has previously had its SEP agency contract terminated by the Department.~~

~~C. The SEP district's selection shall be delivered to the Department no less than six (6) months prior to the effective date of the change in district designation or expiration of the contract with the district's existing SEP agency.~~

~~D. If the SEP district has not delivered to the Department its selection within the timeframe specified in subsection (C) of this rule, the SEP agency for the district shall be selected by the Department pursuant to applicable state statutes and regulations.~~

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8.391.3 Single Entry Point Contract

A. A SEP agency shall be bound to the terms of the contract between the agency and the Department including quality assurance standards and compliance with the Department's rules for SEP agencies and for LTSS Programs.

8391.4 Certification of Single Entry Point Agencies

1. A SEP agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.

a. Certification as a SEP agency shall be based on an evaluation of the agency's performance in the following areas:

i. The quality of the services provided by the agency;

ii. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;

iii. The agency's performance of administrative functions, including reasonable costs per individual receiving services, timely reporting, managing programs in one consolidated unit, on-site visits to individuals, community coordination and outreach and individual monitoring;

iv. Whether targeted populations are being identified and served;

v. Financial accountability; and

vi. The maintenance of qualified personnel to perform the contracted duties.

b. The Department or its designee shall conduct reviews of the SEP agency.

c. At least sixty (60) days prior to expiration of the previous year's certification, the Department shall notify the SEP agency of the outcome of the review, which may be approval, provisional approval, or denial of certification.

8.391.4.A. Provisional Approval of Certification

1. In the event a SEP agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of individuals receiving services.

2. The agency will receive notification of the deficiencies, a request to submit a corrective action plan to be approved by the Department and upon receipt and review of the corrective action plan, at the Department's option, a second sixty-day (60) provisional certification may be approved.

ive action plan, at the Department's option, a second sixty-day (60) provisional certification may be approved.

3. The Department or its designee shall provide technical assistance to facilitate corrective action.

8.391.4.B. Denial of Certification

In the event certification as a SEP agency is denied, the procedure for SEP agency termination or non-renewal of contract shall apply.

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

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.A Administration of a Single Entry Point

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

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

b. The SEP Agency shall have the capacity to accept funding from multiple sources;

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

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

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

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

8.393.1.B. Community Advisory Committee

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

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

b. The Community Advisory Committee shall provide public input and guidance to the SEP Agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall SEP Agency operations, service quality, individual satisfaction and other related professional problems or issues.

ment, overall SEP Agency operations, service quality, individual satisfaction and other related professional problems or issues.

8.393.1.C. Personnel System

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

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

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

8.393.1.D. Information Management

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1. The SEP Agency shall, in a format specified by the Department, be responsible for the collection and reporting of summary and individual-specific data including but not limited to information and referral services provided by the Agency, program eligibility determination, financial eligibility determination, Support Planning, service authorization, critical incident reporting, monitoring of health and welfare, monitoring of services, resource development and fiscal accountability.

ntability.

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

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

8.393.1.E. Recordkeeping

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

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

2. If the individual is unable to sign a form requiring his/her signature because of a medical condition, a digital signature or any mark the individual is capable of making will be accepted

mark the individual is capable of making will be accepted

in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a guardian or authorized representative will be accepted.

8.393.1.F. Confidentiality of Information

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

ich do not otherwise include protected health information, are open records.

8.393.1.G. Individual Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

8.393.1.H. Access

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

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

b. The SEP Agency shall comply with nondiscrimination requirements, as defined by federal and Department rules and outlined in contract.

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

8.393.1.I. Staffing Patterns

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

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

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

on with the Department, and, as needed, providing case management services in lieu of the case manager.

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

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

d Adult Long-Term Home Health prior authorizations.

8.393.1.J. Qualifications of Staff

1. The SEP case manager(s) hired on or after October 8, 2021 shall meet minimum standards for HCBS case managers required in Section 8.519.5.B and shall be able to demonstrate competency in pertinent case management knowledge and skills.

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

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

b. Knowledge of and experience working with populations served by the SEP Agency:

c. Interviewing and assessment skills;

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

e. Ability to develop Support Plans and service agreements;

f. Knowledge of LTSS and other community resources; and

g. Negotiation, intervention and interpersonal communication skills.

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

8.393.1.M. Functions of the Case Manager.

1. The SEP Agency's case manager(s) shall be responsible for: intake, screening and referral, Assessment/Reassessment, development of Person-Centered Support Plans, ongoing case management, monitoring of individuals' health and welfare, documentation of contacts and case management activities in the Department-prescribed IMS, resource development, and case closure.

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

condition or as determined by the rules of the LTSS Program in which the individual is enrolled.

b. The case manager shall have in-person monitoring at least one (1) time during the PCSP year. The case manager shall ensure one required monitoring is conducted in-person with the Member, in the Member's place of residence. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which in-person meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

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ent (e.g., natural disaster, pandemic, etc.).

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

case manager or client (e.g., natural disaster, pandemic, etc.).

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

i. The quality of services and supports provided;

ii. The health and safety of the individual; and

iii. The utilization of services.

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

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

ii. Overall level of functioning;

iii. Mental status or cognitive functioning;

iv. Duration of disabilities;

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

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

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

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

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

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

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

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

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

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

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

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f. Assumption of case management duties when necessary.

8.393.1.L. Training of Single Entry Point Agency Staff

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

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

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

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

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

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

v. Federal and state requirements for the SEP Agency.

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

8.393.1.M. Provision of Direct Services

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

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

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

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

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

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

district or within the sub-region of the district, as a service external to the SEP Agency. The SEP Agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.

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

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

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8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

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

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8.393.2.A. Protective Services

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

ection 19-13-304, C.R.S., (Colorado Children's Code), Section 18-6.5-108, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Section 26-3.1-102, C.R.S., (Human Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

8.393.2.B. Intake, Screening and Referral

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

a. The completion and documentation of the intake, screening and referral functions using the Department prescribed intake, screening and referral instruments in the IMS;

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

b. The provision of information and referral to other agencies, as needed, and the documentation of those referrals in the IMS;

c. A screening to determine whether a LOC Screen is indicated;

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

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

2. When LTSS are to be reimbursed through one or more of the publicly funded LTSS Programs served by the SEP system:

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

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

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

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

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

iv. Conducting and documenting follow-up activities to complete the LOC Screen and facilitate the completion of the financial eligibility determination, as needed.

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

d. Individuals shall be notified by the SEP Agency at the time of their application for publicly funded LTSS that they have the right to appeal actions of the SEP Agency, the Department, and contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

before an Administrative Law Judge.

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

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

8.393.2.C. Initial Level of Care Eligibility Determination

1. The SEP Agency shall complete the LOC Screen within the following time frames:

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

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

notification by the nursing facility.

c. For a resident who is being admitted to the nursing facility from the hospital, the SEP Agency shall complete the LOC Screen, including a PASRR Level 1 Screen within two (2) working days after notification, as required by Section 8.401.18 .PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

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

ram or between nursing facilities, the SEP Agency shall complete the LOC Screen within five (5) working days after notification by the nursing facility.

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e. For an individual who is being transferred from a hospital to an HCBS program, the SEP Agency shall complete the LOC Screen within two (2) working days after notification from the hospital.

2. The start date of the Level of Care Eligibility Determination shall not be back dated by the SEP. Neither the state nor its agent(s) will approve late PAR revisions. See Section 8.486.30 LEVEL OF CARE ELIGIBILITY DETERMINATION and Section 8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES.

3. A trained SEP Agency Case Manager shall complete the LOC Screen for LTSS programs, in accordance with Section 8.401.1.

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

4. The SEP Agency shall assess the individual's level of care in-person, in the location where the person currently resides. Upon Department approval, the LOC Screen may be conducted by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which in-person meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

n meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

5. The Applicant may choose to have family members, advocates, friends and/or caregivers, as appropriate, participate as respondents in the assessment process either by attending with the Applicant or separate interviews with the case manager.

5. The SEP Agency shall conduct the following activities for a Level of Care Eligibility Determination of an Applicant:

a. Obtain supporting diagnostic information, including but not limited to, the Professional Medical Information Page (PMIP) form from the individual's medical provider for individuals in nursing facilities, HCBS Community Mental Health Supports Waiver (HCBS-CMHS), Brain Injury Waiver (HCBS-BI), Elderly, Blind and Disabled Wavier (HCBS-EBD), Complementary and Integrated Health Waiver (HCBS-CHI) and Children with a Life Limiting Illness Waiver (HCBS-CLLI).

CHI) and Children with a Life Limiting Illness Waiver (HCBS-CLLI).

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

b. Determine the individual's level of care during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting using a Department prescribed instrument as outlined in Section 8.401.1.

c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.10.15.

d. Assess the need for LTSS services using a Department prescribed instrument.

e. For HCBS Programs and admissions to nursing facilities from the community, a copy of the LOC Eligibility Determination shall be sent to the prospective provider agency and a copy shall be retained in the agency's case record for the individual. If there are changes in the individual's condition which significantly change the payment or services amount, a copy of the LOC Eligibility Determination documenting the

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change must be sent to the provider agency and a copy is to be maintained in the agency's case record for the individual.

record for the individual.

f. When the SEP Agency assesses the individual's level of care using the Department's prescribed instrument, the Assessment is not an adverse action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into an LTSS Program by the SEP based on the thresholds for Level of Care Eligibility Determination as outlined in Section 8.401.1. The appeal process is governed by the provisions of Section 8.057.

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

complete the following activities for discharges from nursing facilities:

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

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

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

i. If the end date for the nursing facility is indefinite, the SEP Agency shall assign an end date not past one (1) year from the date of the most recent Level of Care Eligibility Determination.

ii. If the Level of Care Eligibility Determination is less than six (6) months, the SEP Agency shall generate a new Level of Care Determination that reflects the end date that was assigned to the nursing facility.

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

iv. The SEP Agency shall provide the Level of Care Determination to the eligibility enrollment specialist at the county department of social services.

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

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

a. Coordinate the admission date with the facility;

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

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

d. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the Level of Care Eligibility Determination is not six (6) months old or older.

8.393.2.D. Ongoing Level of Care Eligibility Determination

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1. The case manager shall determine level of care eligibility on an ongoing basis by completing the LOC Screen at least one (1) but no more than three (3) months before the required

completion date. The case manager shall complete a LOC Screen of an individual receiving services within twelve (12) months of the initial or most recent LOC screen.

2. A Level of Care Eligibility Determination shall be completed sooner if the individual's condition changes or if required by program criteria. The case manager shall document changes utilizing the LOC Screen.

3. Ongoing Level of Care Determination assessments shall be made according to 8.393.2.C.4 and shall include the following activities:

a. Review Person-Centered Support Plan, service agreements and provider contracts or agreements;

b. Evaluate effectiveness, appropriateness and quality of services and supports;

c. Verify continuing Medicaid eligibility, other financial and program eligibility;

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

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

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

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

4. The SEP Agency shall be responsible for completing Level of Care Eligibility Determination Reassessments of individuals receiving care in a nursing facility. A Reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a Reassessment or if the case manager assigns a definite determination end date. The nursing facility shall be responsible to send the SEP Agency a referral for a Reassessment, as needed.

as needed.

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

manager or client (e.g. natural disaster, pandemic, etc.).

8.393.2.E. Person-Centered Support Plan

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

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

3. The SEP Agency shall:

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

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

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

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

e. Formalize the Person-Centered Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;

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

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

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

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

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

k. Explain the appeals process to the individual.

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

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

b. Is led by the individual, the individual's parent's (if the individual is a minor), and/or the individual's authorized representative;

c. Includes people chosen by the individual;

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

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

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

5. Prudent purchase of services:

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

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

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

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

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

ic, etc.).

8.393.2.F. Cost Containment

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

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

remain intact during this review process.

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

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

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

8.393.2.G. Ongoing Case Management

1. The functions of the ongoing case manager shall be:

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

b. Person Centered Support Plan (PCSP) Development: The case manager shall work with individuals to design and update a PCSP that address individuals' goals and assessed needs and preferences;

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

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

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1. Be performed when necessary to address health and safety and services in the PCSP.

2. Include activities to ensure:

A. Services are being furnished in accordance with the individual's PCSP

B. Services in the PCSP are adequate; and

C. Necessary adjustments in the PCSP and service arrangements with providers are made if the needs of the individual have changed;

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

, pandemic, etc.)

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

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

s as needed.

3. The case manager may require the Contractor to revise the PCSP and Prior Authorization if the results of the monitoring indicate that the plan is inappropriate, the services as described in the plan are untimely, or the amount of services need to be changed to meet the Client's needs.

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

a. Review of the individual's PCSP and service agreements;:

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

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

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

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

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

g. Referral to community resources as needed.

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

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

ndividual's needs or as required by the program.

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

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

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

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

a. Critical Incident reporting is required when the following occurs

i. Injury/Illness;

ii. Missing Person;

iii. Criminal Activity;

iv. Unsafe Housing/Displacement;

v. Death;

vi. Medication Management Issues;

vii. Other High-Risk Issues;

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

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

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

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

d. Each Critical Incident Report must include:

i. incident type

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

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

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ii. Date and time of incident;

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

iv. Individuals involved;

v. Description of incident, and

vi. Resolution of incident, if applicable.

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

8.393.2.H. Case Recording/Documentation

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

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

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

b. All State-required forms; and

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

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

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

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

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

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

e. The person making each entry must be identified;

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

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

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

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

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

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

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

from one SEP Agency to another, and when a case is closed.

8.393.2.I. Resource Development Committee

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

's community advisory committee shall appoint a resource development committee.

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

rm services.

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

a. The resource development plan shall include:

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

ii. Gaps in LTSS resources within the SEP district;

iii. Strategies for developing needed resources; and

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

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

locally.

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

8.393.3 DENIALS/DISCONTINUATIONS/ADVERSE ACTIONS

8.393.3.A. Denial Reasons and Notification Actions

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

a. Financial Eligibility

i. The eligibility enrollment specialist from the county department of social services shall notify the individual of denial or discontinuation for reasons of financial eligibility and shall inform the individual of appeal rights in accordance with Section 8.057.

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

not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the Department.

b. Functional Eligibility and Target Group

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

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

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

c. Receipt of Services

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

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

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

3) The individual has failed to keep three scheduled assessment appointments within a thirty-day consecutive period; or

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

d. Institutional Status

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

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

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

e. Cost-Effectiveness/Service Limitations

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

3.2.F.

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

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

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

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

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

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

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

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

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

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

uation shall be written on the form.

8.393.3.C. Notification

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

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

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

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

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

8.393.4. COMMUNICATION

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

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

ist with copies of the certification page of the approved ULTC-100.2 form.

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

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

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

8.393.5 LEVEL OF CARE ELIGIBILITY DETERMINATION

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

1. Ensuring that the Level of Care Screen is completed in the IMS in accordance with Section 8.401.1 and justifies that the individual seeking or receiving services is eligible or ineligible for admission to or continued stay in an applicable LTSS program.

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

ity discharge and within eleven (11) business days of receipt of referral.

3. If the assessment indicates approval, the SEP Agency shall notify the appropriate parties.

4. If the assessment indicates denial, the SEP Agency shall notify the appropriate parties in accordance with 8.393.3.A.2.

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

8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

8.393.6.A. Intercounty Transfers

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

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

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

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

ituations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

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

i. Level of Care Eligibility Determination.

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

iii. Verification of Medicaid eligibility status.

8.393.6.B. Inter-district Transfers

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

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

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

ency shall coordinate the transfer with the eligibility enrollment specialist of the new county.

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

d. If the individual is moving from one SEP District to another SEP District to enter an ACF, the transferring SEP Agency shall forward copies of the individual's records to the ACF prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

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

ten (10) working days after notification of the individual's relocation.

f. The receiving SEP Agency shall complete an in person meeting with the individual in the individual's residence and a case summary update within ten (10) working days after the individual's relocation, in

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accordance with assessment procedures for individuals served by SEP Agencies. Upon Department approval, meeting may be completed using virtual technology methods or may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.)

anager or client (e.g., natural disaster, pandemic, etc.)

g. The receiving SEP Agency shall review the PCSP and the LOC Screen and change or coordinate services and providers as necessary.

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

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

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[SECTIONS 8.400.10-17, 8.401.21 and 8.401.4 REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

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8.401.21

.211 Specialized Services shall include the following requirements:

A. Community Mental Health Centers and Case Management Agencyommunity Centered Boards shall be authorized by the State to provide specialized services to individuals in Medicaid nursing facilities.

B. These services shall be reimbursed by the Medicaid program to the community mental health centers or case management agenciesommunity centered boards through The Department of Health Care Policy and Financing. The cost of these services shall not be reported on the Nursing Facility cost report.

C. Specialized services may be provided by agencies other than community mental health centers or case management agenciesommunity centered boards or other designated agencies on a fee for service basis, but the cost of these services shall not be included in the Medicaid cost report or the Medicaid rate paid to the nursing facility.

[SECTION 8.401.4-8.405.2 REMAINS UNCHANGED AND IS NOT AFFECTED BY THIS RULEMAKING]

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8.405.30 ADMISSION PROCEDURES FOR HCBS-DD

.31 CMAs may evaluate members for HCBS-DD services if, in the judgment of the CMA, such services represent a viable alternative to SNF, ICF, or ICF/IID services. The evaluation shall be carried out in accordance with the procedures set forth in 2 CCR Section 503-1.

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~~.32 If the CMA recommends HCBS-DD placement, then the URC/CMA will approve certification for services for the developmentally disabled at the level of care recommended by the CMA. The member will be placed in alternative service.~~

~~Following receipt of the completed LOC Screen and any other supporting information, the URC/CMA will review the information and make a final certification determination.~~

~~If certification is approved, the URC/CMA shall assign an initial length of stay for HCBS-DD services.~~

~~If certification is denied, the decision of the URC/CMA may be appealed in accordance with Section 8.057.~~

.31 CMAs shall use evaluation and admission criteria as identified at 8.7100-8.7500.

[SECTIONS 8.405.4-8.482.77.18 REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

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8.484 HOME- AND COMMUNITY-BASED SERVICES SETTINGS FINAL RULE

8.484.1 STATEMENT OF PURPOSE, SCOPE, AND ENFORCEMENT

8.484.1.A The purpose of this Section 8.484 is to implement the requirements of the federal Home- and Community-Based Services (HCBS) Settings Final Rule, 79 Fed. Reg. 2947 (2014), codified at 42 C.F.R. § 441.301(c)(4). These rules identify individual rights that are protected at settings where people live or receive HCBS. They also set out a process for modifying these rights as warranted in individual cases. These rules apply to all HCBS under all authorities, except where otherwise noted.

8.484.1.B This Section 8.484 is enforced pursuant to existing procedures, subject to the following transition period and corrective action plan (CAP) exceptions:

1. The following settings were presumed compliant during the transition period and remain covered by this presumption until March 17, 2023:

   a. Residential settings owned or leased by individuals receiving HCBS or their families (personal homes);

   b. Professional provider offices and clinics;

   c. Settings where children receive Community Connector services under the Children's Extensive Supports (CES) Waiver; and

   d. Settings where people receive individual Supported Employment services.

2. Any setting for which a Provider Transition Plan (PTP) has been submitted by December 30, 2021 may continue to transition toward compliance according to the schedule set forth in the PTP. This exception is to be narrowly construed and does not apply to other situations, such as, by way of illustration only, non-compliance:

   a. At case management agencies;

   b. At a setting for which a PTP was not submitted by December 30, 2021 for any reason;

   c. At a setting after the applicable deadline in the setting's PTP, with the deadline being (i) three months after the PTP was submitted unless adjusted with departmental approval and (ii) in no event after March 17, 2023, or March 17, 2024 for settings that have received departmental approval for an extension pursuant to the CAP; or

   d. Involving compliance issues that have been verified as resolved through the PTP process and therefore no longer subject to transition.

8.484.2 DEFINITIONS

8.484.2.A Age Appropriate Activities and Materials means activities and materials that foster social, intellectual, communicative, and emotional development and that challenge the individual to use their skills in these areas while considering their chronological age, developmental level, and physical skills.

8.484.2.B Covered HCBS means any Home- and Community-Based Service(s) provided under the Colorado State Medicaid Plan, a Colorado Medicaid waiver program, or a State-funded program administered by the Department. This category excludes Respite Services, Palliative/Supportive Care services provided outside the child's home under the Children with Life-Limiting Illness Waiver, and Youth Day Services under the CES Waiver.

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~~8.484.2.C HCBS Setting means any physical location where Covered HCBS are provided.~~

~~1. HCBS Settings include, but are not limited to, Provider-Owned or -Controlled Non-residential Settings, Other Non-residential Settings, Provider-Owned or -Controlled Residential Settings, and Other Residential Settings.~~

~~2. If Covered HCBS are provided at a physical location to one or more individuals, the setting is considered an HCBS Setting, regardless of whether some individuals at the setting do not receive Covered HCBS. The requirements of this Section 8.484 apply to the setting as a whole and protect the rights of all individuals receiving services at the setting regardless of payer source.~~

~~8.484.2.D Informed Consent means the informed, freely given, written agreement of the individual (or, if authorized, their guardian or other legally authorized representative) to a Rights Modification. The case manager ensures that the agreement is informed, freely given, and in writing by confirming that the individual (or, if authorized, their guardian or other legally authorized representative) understands all of the information required to be documented in Section 8.484.5 and has signed the Department-prescribed form to that effect.~~

~~8.484.2.E Intensive Supervision means one-on-one (1:1), line-of-sight, or 24-hour supervision. Intensive Supervision is a Rights Modification if the individual verbally or non-verbally expresses that they do not want the supervision or if the supervision would be covered by the Department's processes for rights suspensions or restrictive procedures pursuant to the version of Sections 8.600.4, 8.604.3, and 8.608.1-2 in effect on December 30, 2021.~~

~~8.484.2.F Other Non-residential Setting means a physical location that is non-residential and that is not owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing nonresidential services.~~

~~1. Other Non-residential Settings include, but are not limited to, locations in the community where Covered HCBS are provided.~~

~~8.484.2.G Other Residential Setting means a physical location that is residential and that is not owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing residential services.~~

~~1. Other Residential Settings include, but are not limited to, Residential Settings owned or leased by individuals receiving HCBS or their families (personal homes) and those owned or leased by relatives paid to provide HCBS unless such relatives are independent contractors of HCBS providers.~~

~~8.484.2.H Person-Centered Support Plan means a service and support plan that is directed by the individual whenever possible, with the individual's representative acting in a participatory role as needed, is prepared by the case manager under Sections 8.393.2.E or 8.519.11, identifies the supports needed for the individual to achieve personally identified goals, and is based on respecting and valuing individual preferences, strengths, and contributions.~~

~~8.484.2.I Plain Language means language that is understandable to the individual and in their native language, and it may include pictorial methods, if warranted;~~

~~8.484.2.J Provider-Owned or -Controlled Non-residential Setting means a physical location that is non-residential and that is owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing non-residential services.~~

~~1. Provider-Owned or -Controlled Non-residential Settings include, but are not limited to, provider-owned facilities where Adult Day, Day Treatment, Specialized Habilitation,~~

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Supported Community Connections, Prevocational Services, and Supported Employment Services are provided.

8.484.2.K Provider-Owned or -Controlled Residential Setting means a physical location that is residential and that is owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing residential services.

1. Provider-Owned or -Controlled Residential Settings include, but are not limited to, Alternative Care Facilities (ACFs); Supported Living Program (SLP) and Transitional Living Program (TLP) facilities; group homes for adults with intellectual or developmental disabilities (IDD); Host Homes for adults with IDD; any Individual Residential Services and Supports (IRSS) setting that is owned or leased by a service provider or independent contractor of such a provider; and foster care homes, Host Homes, group homes, residential child care facilities, and Qualified Residential Treatment Programs (QRTPs) in which Children's Habilitation Residential Program (CHRP) services are provided.

8.484.2.L Restraint means any manual method or direct bodily contact or force, physical or mechanical device, material, or equipment that restricts normal functioning or movement of all or any portion of a person's body, or any drug, medication, or other chemical that restricts a person's behavior or restricts normal functioning or movement of all or any portion of their body. Physical or hand-over-hand assistance is a Restraint if the individual verbally or non-verbally expresses that they do not want the assistance or if the assistance is a safety or emergency control procedure or would be covered by the Department's processes for rights suspensions or restrictive procedures pursuant to the version of Sections 8.600.4, 8.604.3, and 8.608.1-2 in effect on December 30, 2021.

8.484.2.M Restrictive or Controlled Egress Measures means devices, technologies, or approaches that have the effect of restricting or controlling egress or monitoring the coming and going of individuals. The following measures are deemed to have such an effect and are Restrictive or Controlled Egress Measures: locks preventing egress; audio monitors, chimes, motion-activated bells, silent or auditory alarms, and alerts on entrances/exits at residential settings; and wearable devices that indicate to anyone other than the wearer their location or their presence/absence within a building. Other measures that have the effect of restricting or controlling egress or monitoring the coming and going of individuals are also Restrictive or Controlled Egress Measures.

8.484.2.N Rights Modification means any situation in which an individual is limited in the full exercise of their rights.

1. Rights Modifications include, but are not limited to:

a. the use of Intensive Supervision if deemed a Rights Modification under the definition in Section 8.484.2.E above;

b. the use of Restraints;

c. the use of Restrictive or Controlled Egress Measures;

d. modifications to the other rights in Section 8.484.3 (basic criteria applicable to all HCBS Settings) and Section 8.484.4 (additional criteria for HCBS Settings);

e. any provider actions to implement a court order limiting any of the foregoing individual rights;

f. rights suspensions under Section 25.5-10-218(3), C.R.S.; and

g. all situations formerly covered by the Department's processes for rights suspensions or restrictive procedures pursuant to the version of Sections 8.600.4, 8.604.3, and 8.608.1-2 in effect on December 30, 2021.

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2. Modifications to the rights to dignity and respect, the rights in Sections 8.484.3.A.6-11 (covering such matters as person-centeredness; civil rights; freedom from abuse; and Plain-Language explanations of rights, dispute resolution policies, and grievance/complaint procedures), and the right to physical accessibility are not permitted.

3. For children under age 18, a limitation or restriction to any of the rights in Sections 8.484.3 and 8.484.4 that is typical for children of that age, including children not receiving HCBS, is not a Rights Modification. Consider age-appropriate behavior when assessing what is typical for children of that age. If the child is not able to fully exercise the right because of their age, then there is no need to pursue the Rights Modification process under Section 8.484.5. However, if the proposed limitation or restriction is above and beyond what a typically developing peer would require, then it must be handled as a Rights Modification under Section 8.484.5.

8.484.3 BASIC CRITERIA APPLICABLE TO ALL HCBS SETTINGS

8.484.3.A All HCBS Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as indicated in their Person-Centered Support Plan, subject to the Rights Modification process in Section 8.484.5:

1. The setting is integrated in and supports full access of individuals to the greater community, including opportunities to seek employment and work in competitive integrated settings, control personal resources, receive services in the community, and engage in community life, including with individuals who are not paid staff/contractors and do not have disabilities, to the same degree of access as individuals not receiving HCBS.

   a. Individuals are not required to leave the setting or engage in community activities. Individuals must be offered and have the opportunity to select from Age Appropriate Activities and Materials both within and outside of the setting.

   b. Integration and engagement in community life includes supporting individuals in accessing public transportation and other available transportation resources.

   c. Individuals receiving HCBS are not singled out from other community members through requirements of individual identifiers, signage, or other means.

   d. Individuals may communicate privately with anyone of their choosing.

   e. Methods of communication are not limited by the provider.

      i. The setting must always provide access to shared telephones if it is a Provider-Owned or -Controlled Residential Setting and during business hours if it is a Provider-Owned or -Controlled Non-residential Setting.

      ii. Individuals are allowed to maintain and use their own cell phones, tablets, computers, and other personal communications devices, at their own expense.

      iii. Individuals are allowed to access telephone, cable, and Ethernet jacks, as well as wireless networks, in their rooms/units, at their own expense.

   f. Individuals have control over their personal resources. If an individual is not able to control their resources, an assessment of their skills must be completed and

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documented in their Person-Centered Support Plan. The assessment and Person-Centered Support Plan must identify what individualized assistance the provider or other person will provide and any training for the individual to become more independent, based on the outcome of the assessment.

i. Providers may not insist on controlling an individual's funds as a condition of providing services and may not require individuals to sign over their Social Security checks or paychecks.

ii. A provider may control an individual's funds if the individual so desires, or if it has been designated as their representative payee under the Social Security Administration's (SSA's) policies. If a provider holds or manages an individual's funds, their signed Person-Centered Support Plan must:

a) Document the request or representative payee designation;

b) Document the reasons for the request or designation; and

c) Include the parties' agreement on the scope of managing the funds, how the provider should handle the funds, and what they define as "reasonable amounts" under Section 25.5-10-227, C.R.S.

iii. The provider must ensure that the individual can access and spend money at any time, including on weekends, holidays, and evenings, including with assistance or supervision if necessary.

2. The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the Person-Centered Support Plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

3. The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.

a. The right of privacy includes the right to be free of cameras, audio monitors, and devices that chime or otherwise alert others, including silently, when a person stands up or passes through a doorway.

i. The use of cameras, audio monitors, chimes, and alerts in (a) interior areas of residential settings, including common areas as well as bathrooms and bedrooms, and in (b) typically private areas of non-residential settings, including bathrooms and changing rooms, is acceptable only under the standards for modifying rights on an individualized basis pursuant to Section 8.484.5.

ii. If an individualized assessment indicates that the use of a camera, audio monitor, chime, or alert in the areas identified in the preceding paragraph is necessary for an individual, this modification must be reflected in their Person-Centered Support Plan. The Person-Centered Support Plans of other individuals at that setting must reflect that they have been informed in Plain Language of the camera(s)/monitor(s)/chime(s)/alert(s) and any methods in place to mitigate the impact on their privacy. The provider must ensure that only appropriate staff/contractors have access to the camera(s)/monitor(s)/chime(s)/alert(s) and any recordings and files they generate, and it must have a method for secure disposal or destruction of any recordings and files after a reasonable period.

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iii. Cameras, audio monitors, chimes, and alerts on staff-only desks and exterior areas, cameras on the exterior sides of entrances/exits, and cameras typically found in integrated employment settings, generally do not raise privacy concerns, so long as their use is similar to that practiced at non-HCBS Settings. In provider-owned or -controlled settings, notice must be provided to all individuals that they may be on camera and specify where the cameras are located. If such devices have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to the Rights Modification requirements of Section 8.484.5.

iv. Audio monitors, chimes, motion-activated bells, silent or auditory alarms, and alerts on entrances/exits at residential settings have the effect of restricting or controlling egress and are subject to the Rights Modification requirements of Section 8.484.5. If such devices on entrances/exits at non-residential settings have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to the Rights Modification requirements of Section 8.484.5.

b. The right of privacy includes the right not to have one's name or other confidential items of information posted in common areas of the setting.

4. The setting fosters individual initiative and autonomy, and the individual is afforded the opportunity to make independent life choices. This includes, but is not limited to, daily activities, physical environment, and with whom to interact.

5. The setting facilitates individual choice regarding services and supports, and who provides them.

6. The Person-Centered Support Plan drives the services afforded to the individual, and the setting staff/contractors are trained on this concept and person-centered practices, as well as the concept of dignity of risk.

7. Each individual is afforded the opportunity to:

a. Lead the development of, and grant Informed Consent to, any provider-specific treatment, care, or support plan;

b. Have freedom of religion and the ability to participate in religious or spiritual activities, ceremonies, and communities;

c. Live and receive services in a clean, safe environment;

d. Be free to express their opinions and have those included when any decisions are being made affecting their life;

e. Be free from physical abuse and inhumane treatment;

f. Be protected from all forms of sexual exploitation;

g. Access necessary medical care which is adequate and appropriate to their condition;

h. Exercise personal choice in areas including personal style;

i. Receive the same consideration and treatment as anyone else regardless of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability; and

j. Accept or decline services and supports of their own free will and on the basis of informed choice.

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8. Nothing in this rule shall be construed to prohibit necessary assistance as appropriate to those individuals who may require such assistance to exercise their rights.

9. Nothing in this rule shall be construed to interfere with the ability of a guardian or other legally authorized representative to make decisions within the scope of their guardianship order or other authorizing document.

10. Providers shall supply all individuals at the setting with a Plain Language explanation of their rights under this Section 8.484.

11. Providers shall supply all individuals at the setting with a Plain Language explanation of available dispute resolution and grievance/complaint procedures, along with outside agency contact information, including phone numbers, for assistance. Providers must allow grievances/complaints to be submitted anonymously and at any time (not subject to a deadline).

8.484.4 ADDITIONAL CRITERIA FOR HCBS SETTINGS

8.484.4.A Provider-Owned or -Controlled Residential Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as indicated in their Person-Centered Support Plan, subject to the Rights Modification process in Section 8.484.5:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, a lease, residency agreement, or other form of written agreement must be in place for each individual, and the document must provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

    a. The lease, residency agreement, or other written agreement must:

        i. Provide substantially the same terms for all individuals;

        ii. Be in Plain Language, or if the provider/its independent contractor cannot adjust the language, at least be explained to the individual in Plain Language;

        iii. Provide the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of their State, county, city, or other designated entity (or comparable responsibilities and protections, as the case may be), and indicate the authorities that govern these responsibilities, protections, and related disputes;

        iv. Specify that the individual will occupy a particular room or unit;

        v. Explain the conditions under which people may be asked to move or leave;

        vi. Provide a process for individuals to dispute/appeal and seek review by a neutral decisionmaker of any notice that they must move or leave, or tell individuals where they can easily find an explanation of such a process, and state this information in any notice to move or leave;

        vii. Specify the duration of the agreement;

        viii. Specify rent or room-and-board charges;

        ix. Specify expectations for maintenance;

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x. Specify that staff/contractors will not enter a unit without providing advance notice and agreeing upon a time with the individual(s) in the unit;

xi. Specify refund policies in the event of a resident's absence, hospitalization, voluntary or involuntary move to another setting, or death; and

xii. Be signed by all parties, including the individual or, if within the scope of their authority, their guardian or other legally authorized representative.

b. The lease, residency agreement, or other written agreement may:

i. Include generally applicable limits on furnishing/decorating of the kind that typical landlords might impose; and

ii. Provide for a security deposit or other provisions outlining how property damage will be addressed.

c. The lease, residency agreement, or other written agreement may not modify the individual rights protected under Sections 8.484.3 and 8.484.4, such as (a) by imposing individualized terms that modify these conditions or (b) by requiring individuals to comply with house rules or resident handbooks that modify everyone's rights.

d. Providers and their independent contractors must engage in documented efforts to resolve problems and meet residents' care needs before seeking to move individuals or asking them to leave. Providers and their independent contractors must have a substantial reason for seeking any move/eviction (e.g., protection of someone's health/safety), and minor personal conflicts do not meet this threshold.

e. A violation of a lease or residency agreement, a change in the resident's medical condition, or any other development that leads to a notice to leave must include at least 30 days' notice to the individual (or, if authorized, their guardian or other legally authorized representative).

f. If an individual has not moved out after the end of a 30-day (or longer) notice period, the provider/its independent contractor may not act on its own to evict the individual until the individual has had the opportunity to pursue and complete any applicable grievance, complaint, dispute resolution, and/or court processes, including obtaining a final decision on any appeal, request for reconsideration, or further review that may be available.

g. A provider/its independent contractor may not require an individual who has nowhere else to live to leave the setting.

h. This Section 1 does not apply to children under age 18.

2. Individuals have the right to dignity and privacy, including in their living/sleeping units. This right to privacy includes the following criteria:

a. Individuals must have a key or key code to their home, a bedroom door with a lock and key, lockable bathroom doors, privacy in changing areas, and a lockable place for belongings, with only appropriate staff/contractors having keys to such doors and storage areas. Staff/contractors must knock and obtain permission before entering individual units, bedrooms, bathrooms, and changing areas. Staff/contractors may

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use keys to enter these areas and to open private storage spaces only under limited circumstances agreed upon with the individual.

b. Individuals shall have choice in a roommate/housemate. Providers must have a process in place to document expectations and outline the process to accommodate choice.

c. Individuals have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment and, for individuals age 18 and older, complying with the applicable lease, residency agreement, or other written agreement.

3. The Residential Setting does not have institutional features not found in a typical home, such as staff uniforms; entryways containing numerous staff postings or messages; or labels on drawers, cupboards, or bedrooms for staff convenience.

4. Individuals have the freedom and support to determine their own schedules and activities, including methods of accessing the greater community;

5. Individuals have access to food at all times, choose when and what to eat, have input in menu planning (if the setting provides food), have access to food preparation and storage areas, can store and eat food in their room/unit, and have access to a dining area for meals/snacks with comfortable seating where they can choose their own seat, choose their company (or lack thereof), and choose to converse (or not);

6. Individuals are able to have visitors of their choosing at any time and are able to socialize with whomever they choose (including romantic relationships);

7. The setting is physically accessible to the individual, and the individual has unrestricted access to all common areas, including areas such as the bathroom, kitchen, dining area, and comfortable seating in shared areas. If the individual wishes to do laundry and their home has laundry machines, the individual has physical access to those machines; and

8. Individuals are able to smoke and vape nicotine products in a safe, designated outdoor area, unless prohibited by the restrictions on smoking near entryways set forth in the Colorado Clean Indoor Air Act, Section 25-14-204(1)(ff), C.R.S., or any law of the county, city, or other local government entity.

8.484.4.B Other Residential Settings in which one or more individuals receiving 24-hour residential services and supports reside must have all of the qualities of and protect all of the same individual rights as Provider-Owned or -Controlled Residential Settings, as listed above, other than Section 8.484.4.A relating to a lease or other written agreement providing protections against eviction, subject to the Rights Modification process in Section 8.484.5.

8.484.4.C Other Residential Settings in which no individuals receiving 24-hour residential services and supports reside are excluded from this Section 8.484.4.

1. This group of settings includes, but is not limited to, homes in which no individual receives IRSS and one or more individuals receive Consumer-Directed Attendant Support Services (CDASS), Health Maintenance Services, Homemaker Services, In-Home Support Services (IHSS), and/or Personal Care Services.

8.484.4.D Provider-Owned or -Controlled Non-residential Settings must have all of the qualities of and protect all of the same individual rights as Provider-Owned or -Controlled Residential Settings, as listed above, other than Section 8.484.4.A relating to a lease or other written agreement providing protections against eviction and Section 8.484.4.B relating to privacy in one's living/sleeping unit, subject to the Rights Modification process in Section 8.484.5.

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1. Provider-Owned or -Controlled Non-residential Settings must afford individuals privacy in bathrooms and changing areas and a lockable place for belongings, with only the individuals and appropriate staff/contractors having keys to such doors and storage areas.

2. This Section 8.484.4 does not require Non-residential Settings to provide food if they are not already required to do so under other authorities. This Section 8.484.4 does require Non-residential Settings to ensure that individuals have access to their own food at any time.

8.484.4.E Other Non-residential Settings must have all of the qualities of and protect the same individual rights as Provider-Owned or -Controlled Non-residential Settings, as stated immediately above, to the same extent for HCBS participants as they do for other individuals, subject to the Rights Modification process in Section 8.484.5.

8.484.5 RIGHTS MODIFICATIONS

8.484.5.A Any modification of an individual's rights must be supported by a specific assessed need and justified in the Person-Centered Support Plan, pursuant to the process set out in Sections 8.484.5.C and 8.484.5.D below. Rights Modifications may not be imposed across-the-board and may not be based on the convenience of the provider. The provider must ensure that a Rights Modification does not infringe on the rights of individuals not subject to the modification. Wherever possible, Rights Modifications should be avoided or minimized, consistent with the concept of dignity of risk.

8.484.5.B The process set out in Sections 8.484.5.C-D below applies to all Rights Modifications.

8.484.5.C For a Rights Modification to be implemented, the following information must be documented in the individual's Person-Centered Support Plan, and any provider implementing the Rights Modification must maintain a copy of the documentation:

1. The right to be modified.

2. The specific and individualized assessed need for the Rights Modification.

3. The positive interventions and supports used prior to any Rights Modification, as well as the plan going forward for the provider to support the individual in learning skills so that the modification becomes unnecessary.

4. The less intrusive methods of meeting the need that were tried but did not work.

5. A clear description of the Rights Modification that is directly proportionate to the specific assessed need.

6. A plan for regular collection of data to measure the ongoing effectiveness of and need for the Rights Modification, including specification of the positive behaviors and objective results that the individual can achieve to demonstrate that the Rights Modification is no longer needed.

7. An established timeline for periodic reviews of the data collected under the preceding paragraph. The Rights Modification must be reviewed and revised upon reassessment of functional need at least every 12 months, and sooner if the individual's circumstances or needs change significantly, the individual requests a review/revision, or another authority requires a review/revision.

8. The Informed Consent of the individual (or, if authorized, their guardian or other legally authorized representative) agreeing to the Rights Modification.

9. An assurance that interventions and supports will cause no harm to the individual, including documentation of the implications of the modification for the individual's everyday life and the ways the modification is paired with additional supports to prevent harm or discomfort and to mitigate any undesired effects of the modification.

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10. Alternatives to consenting to the Rights Modification, along with their most significant likely consequences.

11. An assurance that the individual will not be subject to retaliation or prejudice in their receipt of appropriate services and supports for declining to consent or withdrawing their consent to the Rights Modification.

8.484.5.D Additional Rights Modification process requirements:

1. Prior to obtaining Informed Consent, the case manager must offer the individual the opportunity to have an advocate, who is identified and selected by the individual, present at the time that Informed Consent is obtained. The case manager must offer to assist the individual, if desired, in identifying an independent advocate who is not involved with providing services or supports to the individual. These offers and the individual's response must be documented by the case manager.

2. Any providers that desire or expect to be involved in implementing a Rights Modification may supply to the case manager information required to be documented under this Section 8.484.5, except for documentation of Informed Consent and the offers and response relating to an advocate, which may be obtained and documented only by the case manager. The individual determines whether any information supplied by the provider is satisfactory before the case manager enters it into their Person-Centered Support Plan.

8.484.5.E Use of Restraints

1. If Restraints are used with an individual at an HCBS Setting, their use must:

a. Be based on an assessed need after all less restrictive interventions have been exhausted;

b. Be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights protected under Section 8.484.3, consistent with the Rights Modification process in this Section 8.484.5; and

c. Be compliant with any applicable waiver.

2. Prone Restraints are prohibited in all circumstances. Nothing in this Section E permits the use of any Restraint that is precluded by other authorities.

8.484.5.F If Restrictive or Controlled Egress Measures are used at an HCBS Setting, they must:

1. Be implemented on an individualized (not setting-wide) basis;

2. Make accommodations for individuals in the same setting who are not at risk of unsafe wandering or exit-seeking behaviors;

3. Be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights protected under Section 8.484.3, consistent with the Rights Modification process in this Section 8.484.5, with the documentation including:

a. An assessment of the individual's unsafe wandering or exit-seeking behaviors (and the underlying conditions, diseases, or disorders relating to such behaviors) and the need for safety measures;

b. Options that were explored before any modifications occurred to the Person-Centered Support Plan;

c. The individual's understanding of the setting's safety features, including any Restrictive or Controlled Egress Measures;

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d. The individual's choices regarding measures to prevent unsafe wandering or exit-seeking;

e. The individual's (or, if authorized, their guardian's or other legally authorized representative's) consent to restrictive- or controlled-egress goals for care;

f. The individual's preferences for engagement within the setting's community and within the broader community; and

g. The opportunities, services, supports, and environmental design that will enable the individual to participate in desired activities and support their mobility; and

4. Not be developed or used for non-person-centered purposes, such as punishment or staff/contractor convenience.

8.484.5.G If there is a serious risk to anyone's health or safety, a Rights Modification may be implemented or continued for a short time without meeting all the requirements of this Section 8.484.5, so long as the provider immediately (a) implements staffing and other measures to deescalate the situation and (b) reaches out to the case manager to set up a meeting as soon as possible, and in no event past the end of the third business day following the date on which the risk arises. At the meeting, the individual can grant or deny their Informed Consent to the Rights Modification. The Rights Modification may not be continued past the conclusion of this meeting or the end of the third business day, whichever comes first, unless all the requirements of this Section 8.484.5 have been met.

8.484.5.H When a provider proposes a Rights Modification and supplies to the case manager all of the information required to be documented under this Section 8.484.5, except for documentation that may be obtained only by the case manager, the case manager shall arrange for a meeting with the individual to discuss the proposal and facilitate the individual's decision regarding whether to grant or deny their Informed Consent. Except when the timeline in Section 8.484.5.G applies, the case manager shall arrange for this meeting to occur by the end of the tenth business day following the date on which they received from the provider of all the required information. The individual may elect to make a final decision during or after this meeting. If the individual does not inform their case manager of their decision by the end of the fifth business day following the date of the meeting, they are deemed not to have consented.

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

8.485.10 LEGAL BASIS

The Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-EBD program is also authorized under state law at C.R.S. section 25.5-6-301 et seq. – as amended.

8.485.20 KEYS AMENDMENT COMPLIANCE

All congregate facilities where any HCBS memberclient resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the Social Security Act of 1935 and 45 C.F.R. Part 1397 (October 1, 1991), by possession of a valid Assisted Living Residence license issued under C.R.S. section 25-27-105, and regulations of CDPHE at 6 CCR 1011-1, Chapters 2 and 7. C.R.S. section 25-27-105 and 6 CCR 1011-1 are hereby incorporated by reference. The incorporation of C.R.S. section 25-27-105 and 6 CCR 1011-1 excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business

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hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.485.30 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;

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

C. Consumer Directed Attendant Support Services;

D. Electronic monitoring;

E. Home Delivered Meals;

F. Home modification;

G. Homemaker services;

H. In-Home Support Services;

I. Life Skills Training;

J. Non-medical transportation;

K. Peer Mentorship;

L. Personal care;

M. Respite care; 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 memberclients 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 Section 8.491.

B. Alternative Care Facility services shall be as defined at Section 8.495.

C. Consumer Directed Attendant Support Services (CDASS) shall be defined at Section 8.510.

D. Electronic monitoring services shall be as defined at Section 8.488.

E. Home Delivered Meals services shall be defined at Section 8.553.

F. Home modification shall be as defined at Section 8.493.

G. Homemaker services shall be as defined at Section 8.490.

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H. In-Home Support Services shall be as defined at Section 8.552.

I. Life Skills Training (LST) services shall be as defined at Section 8.553.

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

K. Peer Mentorship services shall be defined at Section 8.553.

L. Personal care services shall be as defined at Section 8.489.

M. Respite care shall be as defined at Section 8.492.

N. In-Home Support Services shall be as defined at Section 8.552.

O. Transition Setup services shall be as defined at Section 8.553

8.485.50 GENERAL DEFINITIONS

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

B. Assessment shall be as defined at Section 8.390.1..

C. Case Management shall be as defined at Section 8.390.1. including the calculation of memberclient payment and the determination of individual cost-effectiveness.

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

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

F. Uncertified Congregate Facility shall be a facility as defined at Section 8.485.50.E. that is not certified as an Alternative Care Facility. See Section 8.495.1.

G. Continued Stay Review shall be a Reassessment as defined at 10 CCR 2505-10 Sections 8.402.60 and 8.390.1.

H. Corrective Action Plan shall be as defined at Section 8.390.1.

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

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

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K. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized.

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

M. Intake/Screening/Referral shall be as defined 10 CCR 2505-10 Section 8.390.1.K.

N. Level of Care Screen shall be as defined as an assessment conducted in accordance with 10 CCR 2505-10 Section 8.401.

O. Provider agency shall be defined as an agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at Section 8.485.40. A Single Entry Point Agency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria in Sections 8.390-8.393 are met.

P. Reassessment shall be as defined at 10 CCR 2505-10 Section 8.390.1.

Q. Person-Centered Support Plan means as defined in 10 CCR 2505-10 Section 8.390.1.

R. Single Entry Point Agency shall be defined as an organization described at Section 8.390.1.U.

S. The Department shall be defined described in 8.390.1.F.

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

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

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

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

8.485.60 ELIGIBLE PERSONS

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

A. Financial Eligibility

MemberClients shall meet the eligibility criteria as stated at 10 CCR 2505-10 Section 8.100. Clients must also meet criteria specified in the Colorado Department of Human Services Income Maintenance Staff Manual, 9 CCR 2503-1, (2018).

B. Level of Care and Target Group

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

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1. Determined by the Single Entry Point Agency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult; and

2. Determined by a LOC Screen to require the Nursing Facility Level of Care, according to 10 CCR 2505-10 Section 8.401.11 through 8.401.15; or

3. Determined by a LOC Screen to require hospital level of care;

4. A length of stay shall be assigned by the Single Entry Point Agency for approved admissions, according to guidelines at Section 8.402.60.

C. Receiving HCBS-EBD Services

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

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

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

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

D. Institutional Status

1. MemberClients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD services while residing in such institutions unless the Single Entry Point Agency determines the memberclient is eligible for EBD as described in Section 8.486.33.

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

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

   (a) The case manager must terminate the memberclient from the HCBS-EBD program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified LOC Screen for the nursing facility placement, as verified by telephoning the URC.

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

E. Cost-effectiveness

Only memberclients who can be safely served within cost containment, as defined at Section 8.485.50, are eligible for the HCBS-EBD program.

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F. Waiting List

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

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

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

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

a. MemberClients being deinstitutionalized from nursing facilities.

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

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

d. MemberClients requiring nursing facility level of care and who are at risk of imminent nursing facility placement.

8.485.70 START DATE

.71 The start date of eligibility for HCBS-EBD services shall not precede the date that all of the requirements at Section 8.485.60 have been met. The first date for which HCBS-EBD services can be reimbursed shall be the later of any of the following:

A. Financial: The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care: This date is determined by the official assigned start date on the LOC Screen.

C. Receiving Services: This date shall be determined by the date on which the memberclient signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept services.

D. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the hospital or nursing facility.

.72 The start date for CTS may precede HCBS-EBD enrollment when a memberclient meets the conditions set forth at Section 8.486.33. The start date for CTS shall be no more than 180 calendar days before a memberclient's discharge from a nursing facility.

8.485.80 MEMBERCLIENT PAYMENT OBLIGATION-POST ELIGIBILITY TREATMENT OF INCOME (PETI)

.81 When a memberclient has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to 10 CCR 2505-10 section 8.100, the Department may reduce Medicaid payment for Alternative Care Facility services according to the procedures at 10 CCR 2505-10 section 8.486.60.

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8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

.91 The Department or its agent shall develop the Prior Authorization Request (PAR) form in compliance with all applicable regulations, and determine whether services requested are (a) consistent with the memberclient's documented medical condition and Level of Care, (b) reasonable in amount, frequency and duration, (c) not duplicative, (d) not services for which the memberclient is receiving funds to purchase, and (e) do not total more than twenty four (24) hours per day of care.

A. The case manager shall submit prior authorization approvals for all HCBS-EBD services to the fiscal agent within one (1) calendar month after the URC's assigned start date and approval of financial eligibility.

B. The Department or its fiscal agent will approve, deny or return for additional information home modification PARs over $1,000 within ten (10) working days of receipt.

.92 When home modifications are denied, in whole or in part, the Single Entry Point Agency shall notify the memberclient or the memberclient's designated representative of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et. seq.

.93 Revisions requested by providers six months or more after the end date shall always be disapproved.

.94 Approval of the PAR by the Department or its agent shall authorize providers of services under the PCSP to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the memberclient's financial eligibility for long-term care medical assistance (Medicaid) on the dates of service; and upon provider's use of correct billing procedures.

.95 Every PAR shall be supported by information on the PCSP, the LOC Screen and written documentation from the income maintenance technician of the memberclient's current monthly income. All units of service requested on the PAR shall be listed on the PCSP.

.96 If a PAR is for an Alternative Care Facility memberclient who is 300% eligible, all medical and remedial care requested as deductions shall be listed on the MemberClient Payment form.

.97 The start date on the Prior Authorization Request form shall not precede the start date of eligibility for HCBS-EBD services, according to Section 8.485.70, except for CTS. A TCA may provide CTS up to 180 days prior to nursing facility discharge when authorized by the Single Entry Point Agency. The TCA is eligible for reimbursement beginning on the first day of the memberclient's HCBS-EBD enrollment.

.98 The PAR shall not cover a period longer than the length of stay assigned by the URC.

Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.

8.485.200 LIMITATIONS ON PAYMENT TO FAMILY

.201 In no case shall any person be reimbursed to provide HCBS-EBD services to his or her spouse.

.202 Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-EBD program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the memberclient by virtue of blood, marriage, adoption or common law.

.203 The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.

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.204 The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

A. The total number of Medicaid personal care units for a member of the memberclient's family shall not exceed the equivalent of 444 hours per annual certification for HCBS-EBD.

1. The maximum number of Medicaid personal care units per annual certification for HCBS-EBD shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision, and all other administrative costs.

2. The maximum number of hours for personal care units HCBS-EBD shall be 444. Family members must average at least 1.2164 hours of care per day (as indicated on the memberclient's Service Plan) in order to receive the maximum reimbursement.

a. If the certification period for HCBS-EBD is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the memberclient is receiving care by the average hours per day of personal care for a full year (444/365=1.2164).

B. If two or more HCBS-EBD memberclients reside in the same household, family members may be reimbursed up to the maximum for each memberclient if the services are not duplicative and are appropriate to meet the memberclient's needs.

C. When HCBS-EBD funds are utilized for reimbursement of personal care services provided by the memberclient's family, the home care allowance cannot be used to reimburse the family.

D. Restrictions on allowable personal care units shall not apply to parents who provide Attendant services to their eligible children under In-Home Support Services (10 CCR 2505-10 section 8.552).

E. Services other than personal care shall not be reimbursed with HCBS-EBD funds when provided by the memberclient's family, with the exception of Attendant services provided under In-Home Support Services (10 CCR 2505-10 section 8.552).

8.485.300 MEMBERCLIENT RIGHTS

.301 The case manager shall inform persons eligible for HCBS-EBD, in writing, of their right to choose between HCBS-EBD services and nursing facility or hospital care. In addition, the case manager shall discuss the option and potential benefits of in-home support services with all eligible HCBS-EBD memberclients.

8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

8.486.10 HCBS-EBD PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

Single entry point agencies shall comply with single entry point rules at 10 CCR 2505-10 section 8.390, et. seq., governing case management functions, and shall comply with all HCBS-specific requirements in the rest of this section on HCBS-EBD case management functions.

8.486.20 INTAKE

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.21 Refer to Section 8.393.2.B for single entry point intake procedures. The intake form shall be completed before a LOC Screen is initiated. The intake form may also be used as a preliminary case plan form when signed by the Applicant, for purposes of establishing a start date.

.22 Based upon information gathered on the intake form, the case manager shall determine the appropriateness of a referral for a LOC Screen and shall explain the reasons for the decision on the Intake form. The memberclient shall be informed of the right to request a LOC Screen if the memberclient disagrees with the case manager's decision.

8.486.30 LEVEL OF CARE ELIGIBILITY DETERMINATION

.31 If the memberclient is being discharged from a hospital or other institutional setting, the discharge planner shall contact the URC/SEP agency for assessment by emailing or faxing the initial intake and screening form.

.32 The URC/SEP case manager shall view and document the current Personal Care Boarding Home license, if the memberclient lives, or plans to live, in a congregate facility as defined at Section 8.485.50, in order to ensure compliance with Section 8.485.20.

.33 A SEP may determine that a memberclient is eligible for HCBS-EBD while the memberclient resides in a nursing facility when the memberclient meets the eligibility criteria as established at Section 8.400, et seq., the member.client requests CTS and the SEP includes CTS in the memberclient's long-term care plan. If the memberclient has been evaluated with the LOC Screen and has been assigned a length of stay that has not lapsed, the SEP shall not conduct another review when CTS is requested.

8.486.40 HCBS-EBD DENIALS

.41 If a memberclient is determined, at any point in the Level of Care Eligibility Determination process, to be ineligible for HCBS-EBD according to any of the requirements at Section 8.485.60, the memberclient or the memberclient's designated representative shall be notified of the denial and the memberclient's appeal rights in accordance with Long-term Care Single Entry Point System regulations at Section 8.393.3.A.

8.486.50 Case Planning

.51 Case planning shall include the following tasks:

A. Documentation of the memberclient's choice of HCBS-EBD services, nursing home placement, or other services, including a signed statement of choice from the memberclient;

B. Documentation that the memberclient was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the memberclient understands his/her right to change providers;

C. Except when a memberclient is residing in an alternative care facility, documentation to include a process, developed in coordination with the memberclient, the memberclient's family or guardian and the memberclient's physician, by which the memberclient may receive necessary care if the memberclient's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The memberclient and the memberclient's family or guardian shall be duly informed of these alternative care provisions at the time the case plan is initiated.

[SECTION 8.486.60 REMAINS UNCHANGED AND IS UNAFFECTED BY THIS RULEMAKING]

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8.486.70 PRUDENT PURCHASE AND SERVICE FUNDING PRIORITIES

.71 The single entry point agency shall be financially responsible for any services which it authorized to be provided to the memberclient which did not meet regulatory requirements, or which continued to

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be rendered by a provider due to the single entry point agency's failure to timely notify the provider that the memberclient was no longer eligible for services.

8.486.80 COST CONTAINMENT

.81 The case manager shall determine whether the individual meets the cost containment criteria of Section 8.485.50.J by using a State-prescribed PAR form to:

A. Determine the maximum authorized costs for all waiver services and long-term home health services for the period of time covered by the care plan and compute the average cost per day by dividing by the number of days in the care plan period; and

B. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:

1. Enter (in the designated space on the PAR form) the monthly cost of institutional care for the individual; and

2. Subtract from that amount the individual's gross monthly income; and

3. Subtract from that amount the individual's monthly Home Care Allowance authorized amount, if any, and

4. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount.

C. An individual memberclient whose service needs exceed the amount allowed under the memberclient's individual cost containment amount may choose to purchase additional services with personal income, but no memberclient shall be required to do so.

Sections 8.486.90 - 8.486.98 deleted by the Medical Services Board February 9, 2001.

8.486.100 REVISIONS

.101 SERVICES ADDED TO THE CARE PLAN

A. Whenever a change in the care plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the fiscal agent.

1. The revised care plan form shall list the services being revised and shall state the reason for the revision. Services on the revised care plan form, plus all services on the original care plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.

2. The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.

B. If a revised PAR includes a new request for home modification service above the Department prescribed amount, the revised PAR shall also include all documentation listed at Section 8.493.

.102 DECREASE OF SERVICES ON THE CARE PLAN

A. A revised PAR does not need to be submitted if services on the care plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.

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B. If services are decreased without the memberclient's agreement, the case manager shall notify the memberclient of the adverse action and of appeal rights, according to Long-term Care Single Entry Point System regulations at Section 8.393.3.A.

8.486.200 REASSESSMENT

.201 The case manager shall complete a Reassessment of each SEP-managed waiver memberclient before the end of the length of stay assigned by the Utilization Review Contractor at the last level of care determination. The case manager shall initiate a Reassessment more frequently if required by single entry point regulations at 10 CCR 2505-10 section 8.393.25, or when warranted by significant changes that may affect HCBS-EBD eligibility.

.202 The case manager shall submit a continued stay review PAR, in accordance with requirements at 10 CCR 2505-10 section 8.485.90. For memberclients who have been denied by the Utilization Review Contractor at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved LOC Screen. Acceptable documentation of an appeal includes: (a) a copy of the request for reconsideration or the request for appeal, signed by the memberclient and sent to the Utilization Review Contractor or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the Utilization Review Contractor or the Office of Administrative Courts to the memberclient; or (c) a copy of the notice of a scheduled court date. Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed and shall not be accepted as a substitute for the approved LOC Screen. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.486.300 TERMINATION

.301 In accordance with Long-term Care Single Entry Point System regulations at Section 8.393.28, memberclients shall be terminated from any SEP-managed waiver whenever they no longer meet one or more of the eligibility requirements at Section 8.485.60. MemberClients shall also be terminated from the waiver if they die, move out of state or voluntarily withdraw from the waiver.

8.486.400 COMMUNICATION

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

A. The case manager shall inform all Alternative Care Facility memberclients of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

B. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent, the case manager shall provide copies to all the HCBS-EBD providers in the care plan.

C. Within five (5) working days of Level of Care Eligibility Determination the case manager shall send a copy of the Level of Care Eligibility Determination the to all personal care, and adult day services provider agencies on the care plan and to alternative care facilities listed on the care plan.

D. The case manager shall notify the URC, on a form prescribed by the Department, within thirty (30) calendar days, of the outcome of all non-diversions, as defined at Section 8.485.50.

8.486.500 CASE RECORDING/DOCUMENTATION

.501 Case management documentation shall meet all of the standards found at Sections 8,393.2.H.

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~~8.487 HCBS WAIVER PROVIDER AGENCIES~~

~~8.487.10 GENERAL CERTIFICATION STANDARDS~~

~~.11 Provider agencies shall:~~

~~A. Conform to all State established standards for the specific services they provide under this program; and~~

~~B. Abide by all the terms of their provider agreement with the Department; and~~

~~C. Comply with all federal and state statutory requirements. A provider shall not discontinue or refuse services to a memberclient unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.~~

~~.12 Provider agencies shall have written policies and procedures for recruiting, selecting, retaining and terminating employees.~~

~~.13 Provider agencies shall have written policies governing access to duplication and dissemination of information from the memberclient's records in accordance with C.R.S. Section 26-1-114, as amended. Provider agencies shall have written policies and procedures for providing employees with memberclient information needed to provide the services assigned, within the agency policies for protection of confidentiality.~~

~~.14 Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department of Health Care Policy and Financing and shall have written policies and procedures regarding emergency procedures.~~

~~.15 Provider agencies shall have written policies and procedures regarding the handling and reporting of Critical Incidents, including accidents, suspicion of abuse, neglect or exploitation, and criminal activity. Provider agencies shall maintain a log of all complaints and Critical Incidents, which shall include documentation of the resolution of the problem.~~

~~.16 Provider agencies shall maintain records on each memberclient. The specific record for each memberclient shall include at least the following information:~~

~~A. Name, address, phone number and other identifying information about the memberclient; and~~

~~B. Name, address and phone number of the case manager and Single Entry Point Agency; and~~

~~C. Name, address and phone number of the memberclient's physician; and~~

~~D. Special health needs or conditions of the recipient; and~~

~~E. Documentation of the services provided, including where, when, to -whom and by whom the service was provided, and the exact nature of the specific tasks performed, as well as the amount or units of service. Records shall include date, month and year of service, and when applicable, the beginning and the ending time of day; and~~

~~F. Documentation of any changes in the memberclient's condition or needs, as well as documentation of appropriate reporting and action taken as a result; and~~

~~G. For personal care agencies, documentation concerning advance directives shall be present in the memberclient record; and~~

~~H. Documentation of supervision of care; and~~

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I. All information regarding a memberclient shall be kept together for easy access and review by supervisors, program monitors and auditors.

.17 Provider agencies shall maintain a personnel record for each employee. The employee record shall contain at least the following:

A. Documentation of employee qualifications.

B. Documentation of training.

C. Documentation of supervision and performance evaluation.

D. Documentation that the employee was informed of all policies and procedures required by these rules.

E. A copy of the employee's job description.

.18 A provider agency may become separately certified to provide more than one type of HCBS-EBD service if all requirements are met for certification. Administration of the different services provided shall be clearly separate for auditing purposes. The provider agency shall also understand and be able to articulate its different functions and roles as a provider of each service, as well as all the rules that separately govern each of the types of services, in order to avoid confusion on the part of memberclients and others.

.19 Provider agencies shall send billing and other staff to the provider billing training offered by the fiscal agent, at least once each year.

8.487.20 GENERAL CERTIFICATION PROCESS

.21 An agency, as defined at 10 CCR 2505-10 section 8.485.50, seeking certification as an HCBS-EBD provider agency, shall submit a written request to the Department or its agent

.22 Upon receipt of the written request, the Department or its agent shall forward certification information and relevant state application forms to the requesting agency.

.23 Upon receipt of the completed application from the requesting agency, the Department or its agent shall review the information and complete an on-site review of the agency, based on the state regulations for the service for which certification has been requested.

.24 Following completion of the on-site review the Department or its agent shall notify the provider agency applicant of its recommendation by forwarding the following information:

A. Results of the on-site survey;

B. Recommendation of approval, denial or provisional approval of certification;

C. If appropriate, a corrective action plan to satisfy the requirements of a provisional approval.

.25 Determination of certification approval, provisional approval or denial shall be made by the Department within sixty (60) days of receipt of the completed application from the agency.

8.487.30 APPROVAL OF CERTIFICATION

If certification is approved, the Department shall enter into a provider agreement with the certified agency in accordance with 10 CCR 2505-10 section 8.130.

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8.487.40 PROVISIONAL APPROVAL OF CERTIFICATION

.41 If agencies do not meet all state established certification standards, but the deficiencies do not constitute a threat to memberclients' health and safety such agencies may be provisionally certified for a period not to exceed sixty (60) days at the discretion of the state.

.42 If provisional approval has been granted, the Department or its agent shall assure that corrective action has been taken according to the approved plan, and shall conduct an on-site review, if necessary, within the designated time period.

8.487.50 DENIAL OF CERTIFICATION

If the agency is unable to complete an adequate corrective action plan within the prescribed time, certification shall be denied, in accordance with 10 CCR 2505-10 section 8.130.

8.487.60 RECERTIFICATION PROCESS

The Department or its agent shall follow the same procedures as those followed for certification, as described at 10 CCR 2505-10 section 8.487.20.

8.487.70 TERMINATION OF PROVIDER AGREEMENTS

The Department shall initiate termination of a provider agreement if an agency is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The state shall follow procedures at 10 CCR 2505-10 section 8.130.

8.487.80 EMERGENCY TERMINATION OF PROVIDER AGREEMENTS

Emergency termination of any provider agreement shall be in accordance with procedures at 10 CCR 2505-10 section 8.050.

8.487.90 TRANSFER OF OWNERSHIP

.91 The provider shall notify the Department or its agent within five (5) working days of any change of ownership.'

.92 Upon transfer of ownership of the provider agency or facility, the provider certification may be assigned to the new owner only upon the prior written consent of the Department or its agent. Such assignment of the duties and obligations of the existing certification to the new owner shall be for a period of time determined at the discretion of the Department, but not to extend beyond the current end date of the original certification period.

.93 Upon transfer of ownership, the previous owner's existing provider agreement with the Department is immediately terminated, and the new owner must enter into a new provider agreement.

8.487.100 PROVIDER RIGHTS

The Department shall notify provider agencies in writing of any adverse action taken by the Department against the agency, and shall inform the agency of its appeal rights in accordance with the procedures described in 10 CCR 2505-10 section 8.050.

8.487.200 PROVIDER REIMBURSEMENT

.201 Payment to certified HCBS-EBD providers for services provided to eligible memberclients shall be made when claims are submitted in accordance with the following procedures:

A. Claims shall be submitted to the fiscal agent on State-prescribed forms provided by the fiscal agent according to 10 CCR 2505-10 section 8.040 and 10 CCR 2505-10 section 8.043: and

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B. Claim forms shall be filled out completely and correctly; and

C. Payment shall not exceed Department established limits as described under the reimbursement sections for each HCBS-EBD service; and

D. Payment shall be made only for the service or services for which the agency is certified; and

E. Payment shall be made only for the types and amounts of services that are prior authorized by the Department or its agent; and

F. Payment shall be made only for services provided by persons employed by the agency at the time the services were provided.

.202 Provider agencies shall maintain adequate financial records for all claims, including documentation of services as specified at 10 CCR 2505-10 section 8.040.02, 10 CCR 2505-10 section 8.130, and 10 CCR 2505-10 section 8.487.10.

8.488 ELECTRONIC MONITORING

8.488.10 DEFINITIONS

.11 BACKUP SUPPORT PERSON means the person who is responsible for responding in the event of an emergency or when a MemberClient receiving Remote Supports otherwise needs assistance or the equipment used for delivery of Remote Supports stops working for any reason. Backup support may be provided on an unpaid basis by a family member, friend, or other person selected by the MemberClient or on a paid basis by an agency provider.

.12 ELECTRONIC MONITORING SERVICES means electronic equipment or adaptations or other remote supports that are related to an eligible person's disability and/or that enable the person to remain at home, and includes the installation, purchase or rental of electronic monitoring devices which:

A. Enable the MemberClient to secure help in the event of an emergency;

B. May be used to provide reminders to the MemberClient of medical appointments, treatments, or medication schedules;

C. Are required because of the MemberClient's illness, impairment or disability, as documented in the department prescribed LOC Screen, the Assessment, and Service Plan;

D. Are essential to prevent institutionalization of the MemberClient; and,

E. May allow an off-site direct service provider to monitor and respond to a MemberClient's health, safety, and other needs using live communication.

.13 ELECTRONIC MONITORING PROVIDER means a provider agency as defined at Section 8.487 and Section 25.5-6-303. C.R.S., that has met all the certification standards for electronic monitoring services specified in Section 8.488.40.

.14 MONITORING BASE means the off-site location from which the Remote Supports Provider monitors the MemberClient.

.15 REMOTE SUPPORTS mean the provision of support by staff at a Monitoring Base who are engaged with a MemberClient to monitor and respond to the MemberClient's health, safety, and other needs through technology/devices with the capability of live two-way communication.

.16 REMOTE SUPPORTS PROVIDER means the agency provider selected by the MemberClient as the provider of Remote Supports.

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.17 SENSOR means equipment used to notify the Remote Supports Provider of a situation that requires attention or activity which may indicate deviations from routine activity and/or future needs. Examples include, but are not limited to, seizure mats, door sensors, floor sensors, motion detectors, heat detectors, and smoke detectors.

8.488.20 INCLUSIONS

.21 Electronic Monitoring Services shall include personal emergency response systems, medication reminder systems, Remote Supports, or other devices which comply with the definition above and are not included in the non-benefit items below at 10 CCR 2505-10 section 8.488.30.

A. Remote Supports services shall include but are not limited to the following technology options:

1. Motion sensing system;

2. Radio frequency identification;

3. Live audio feed;

4. Web-based monitoring system; or,

5. Another device that facilitates two-way communication.

B. Remote Supports includes the following general provisions:

1. Remote Supports shall only be approved when it is the MemberClient's preference and will reduce the need for in-person care.

21. The MemberClient, their case manager, and the selected Remote Supports provider shall determine whether Remote Supports is sufficient to ensure the MemberClient's health and welfare.

2. Remote Supports shall be provided in real time, not via a recording, by awake staff at a Monitoring Base using the appropriate technology. While Remote Support is being provided, the Remote Support staff shall not have duties other than the provision of Remote Supports.

8.488.30 EXCLUSIONS, RESTRICTIONS AND NON-BENEFIT ITEMS

.31 Electronic Monitoring Services shall be authorized only for MemberClients who live alone, or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision.

A. Remote Supports shall not be utilized for MemberClients who reside in any congregate or HCBS provider owned setting.

.32 Electronic Monitoring Services shall be authorized only for MemberClients who have the physical and mental capacity to utilize the particular system requested for that MemberClient.

.33 Electronic Monitoring Services shall not be authorized under HCBS if the service or device is available as a state plan Medicaid benefit.

.34 The following are not benefits of electronic monitoring services:

A. Augmentative communication devices and communication boards;

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B. Hearing aids and accessories;

C. Phonic ears;

D. Environmental control units, unless required for the medical safety of a memberclient living alone unattended; or as part of Remote Supports;

E. Computers and computer software unrelated to the provision of Remote Supports;

F. Wheelchair lifts for automobiles or vans;

G. Exercise equipment, such as exercise cycles;

H. Hot tubs, Jacuzzis, or similar items.

8.488.40 CERTIFICATION STANDARDS FOR ELECTRONIC MONITORING SERVICES

.41 Electronic monitoring providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD WAIVER PROVIDER AGENCIES.

.42 In addition, electronic monitoring providers shall conform to the following standards for electronic monitoring services:

A. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be FCC registered.

B. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer and/or provider of electronic monitoring shall train the MemberClient in the use of the device.

C. All equipment, materials or appliances shall be tested for proper functioning at the time of installation, and at periodic intervals thereafter, and be maintained based on the manufacturer's recommendations. Any malfunction shall be promptly repaired, and equipment shall be replaced when necessary, including buttons and batteries.

D. All telephone calls generated by electronic monitoring equipment shall be toll-free and all MemberClients shall be allowed to run unrestricted tests on their equipment.

E. Electronic monitoring providers shall send written information to each MemberClient's case manager about the system, how it works, and how it will be maintained.

.43 In addition, Remote Supports Providers shall conform to the following additional standards for provision of Remote Supports services:

A. When Remote Supports includes the use of live audio and/or video equipment that permits a Remote Supports Provider to view activities and/or listen to conversations in the residence, the MemberClient who receives the service and each person who lives with the MemberClient shall consent in writing after being fully informed of what Remote Support entails including, but not limited to:

1. The Remote Supports Provider will observe their activities and/or listen to their conversations in the residence;

2. The location in the residence where the Remote Supports service will take place; and,

3. Whether or not the Remote Supports provider will record audio and/or video.

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4. If the MemberClient or a person who lives with the MemberClient has a guardian, the guardian shall consent in writing. The MemberClient's Case Manager and Remote Supports Provider shall keep a copy of each signed consent form.

B. The Remote Support Provider shall provide a MemberClient who receives Remote Supports with initial and ongoing training on how to use the Remote Supports system(s)

C. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.

D. The Remote Supports provider shall have a backup power system (such as battery power and/or generator) in place at the Monitoring Base in the event of electrical outages. The Remote Supports Provider shall haveadditional backup systems and additional safeguards in place which shall include, but are not limited to, contacting the Backup Support Person in the event the Monitoring Base System stops working for any reason.

E. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.

F. If a known or reported emergency involving a MemberClient arises, the Remote Supports Provider shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the Backup Support Person. The Remote Supports Provider shall maintain contact with the MemberClient during an emergency until emergency personnel or the Backup Support Person arrives.

G. The Backup Support Person shall verbally acknowledge receipt of a request for assistance from the Remote Supports Provider. Text messages, email, or voicemail messages will not be accepted as verbal acknowledgment.

H. When a MemberClient requests in-person assistance, the Backup Support Person shall arrive at the MemberClient's location within a reasonable amount of time (to be specified in documentation maintained by the Remote Support Provider.

I. When a MemberClient needs assistance, but the situation is not an emergency, the Remote Supports provider shall:

1. Address the situation from the Monitoring Base, or,

2. Contact the MemberClient's Backup Support Person if necessary.

J. The Remote Support Provider shall maintain detailed and current written protocols for responding to a MemberClient's needs, including contact information for the Backup Support Person to provide assistance.

K. The Remote Support Provider shall maintain documentation of the protocol to be followed should the MemberClient request that the equipment used for delivery of Remote Supports be turned off.

L. The Remote Supports Provider shall maintain daily service provision documentation that shall include the following:

1. Type of Service,

2. Date of Service,

3. Place of Service,

4. Name of MemberClient receiving service,

5. Medicaid identification number of MemberClient receiving service,

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6. Name of Remote Supports Provider,

7. Identify the Backup Support Person and their contact information, if/when utilized.

8. Begin and end time of the Remote Supports service,

9. Begin and end time of the Remote Supports service when a Backup Support Person is needed on site,

10. Begin and end time of the Backup Support Person when on site, whether paid or unpaid,

11. Number of units of Remote Supports service delivered per calendar day,

12. Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the individual's current Service Plan, which shall be communicated to the individual's case manager.

8.488.50 REIMBURSEMENT METHOD FOR ELECTRONIC MONITORING

.51 Payment for Electronic Monitoring Services shall be the lower of the billed charges or the prior authorized amount.

.52 For Electronic Monitoring, excluding Remote Supports, the unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly.

.53 For Remote Supports, the unit of reimbursement shall include one unit per installation/equipment purchase and/or the units as designated on the Department's fee schedule and/or billing manuals for ongoing Remote Supports service.

.54 Effective 2/1/99, there shall be no reimbursement under this section for Electronic Monitoring Services provided in uncertified congregate facilities.

8.489 PERSONAL CARE

8.489.10 DEFINITIONS

.11 Personal care services means services which are furnished to an eligible memberclient in the memberclient's home to meet the memberclient's physical, maintenance and supportive needs, when those services are not skilled personal care as described in the EXCLUSIONS section below, do not require the supervision of a nurse, and do not require physician's orders.

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

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

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

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

8.489.20 GENERAL PERSONAL CARE RULES

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

.22 EXCLUSIONS AND RESTRICTIONS

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

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

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

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

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

8.489.30 SPECIFIC PERSONAL CARE TASKS

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

A. BATHING

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

B. SKIN CARE:

1. INCLUSIONS:

Skin care is considered unskilled only when skin is unbroken, and when any chronic skin problems are not active. Unskilled skin care must be of a preventive rather than a therapeutic nature, and may include application of non-medicated lotions and solutions, or of lotions and solutions not requiring a physician's prescription; rubbing of reddened areas; reporting of

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changes to supervisor, and application of preventive spray on unbroken skin areas that may be susceptible to development of decubiti. Unskilled skin care does not include any of the care described under skilled skin care in the EXCLUSIONS section below.

2. EXCLUSIONS:

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

C. HAIR CARE

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

D. NAIL CARE

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

E. MOUTH CARE

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

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mouth care; or when there is injury or disease of the face, mouth, head or neck; or in the presence of communicable disease; or when the memberclient is unconscious; or when oral suctioning is required.

F. SHAVING

1. INCLUSIONS:

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

2. EXCLUSIONS

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

G. DRESSING

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

H. FEEDING

I. INCLUSIONS:

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

2. EXCLUSIONS:

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

I. AMBULATION

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

J. EXERCISES

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

K. TRANSFERS

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

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L. POSITIONING

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

M. BLADDER CARE

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

N. BOWEL CARE

1. INCLUSIONS:

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

2. EXCLUSIONS:

Bowel care is considered skilled when skilled transfer or skilled skin care, as described under EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2 or EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the bowel care. Skilled bowel care includes digital stimulation and enemas. Skilled bowel care may

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include care of ostomies that are new and care of ostomies when the memberclient is unable to self-direct the care, provided that sterile technique is not required.

O. MEDICATION REMINDING

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

P. RESPIRATORY CARE

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

Q. ACCOMPANYING

1. INCLUSIONS:

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

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care plan, to the extent of time that the memberclient would otherwise receive personal care services in the home.

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

2. EXCLUSIONS:

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

R. HOMEMAKING

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

S. PROTECTIVE OVERSIGHT

1. INCLUSIONS:

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

2. EXCLUSIONS:

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

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

8.489.40 CERTIFICATION STANDARDS FOR PERSONAL CARE SERVICES

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

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

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

A. Orientation of staff to agency policies and procedures.

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B. Arrangement and documentation of training.

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

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

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

F. Meetings and conferences with staff as necessary.

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

H. Investigation of complaints and critical incidents.

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

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

K. Oversight of record keeping by staff.

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Billing for travel time is prohibited.

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

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

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

.45 Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall

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be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal agent.

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

8.489.50 REIMBURSEMENT

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

.52 Payment does not include travel time to or from the memberclient's residence.

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

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

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

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

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

.58 Cost Reporting

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

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

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

8.490 HOMEMAKER SERVICES

8.490.1 DEFINITIONS

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

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Homemaker Services means general household activities provided in the home of an eligible memberclient provided by a Homemaker Provider Agency to maintain a healthy and safe home environment for a memberclient, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

8.490.2 ELIGIBLE MEMBERCLIENTS

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

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

8.490.3 BENEFITS

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

8.490.3.B. Benefits include:

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

2. Meal preparation.

3. Dishwashing.

4. Bedmaking.

5. Laundry.

6. Shopping.

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

8.490.3.C. Benefits do not include:

1. Personal care services.

2. Services the person can perform independently.

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

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

8.490.4 HOMEMAKER PROVIDER AGENCY RESPONSIBILITIES

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

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

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

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

2. Proper food handling and storage techniques.

3. Basic infection control techniques including universal precautions.

4. Informing staff of policies concerning emergency procedures.

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

1. Train staff on agency policies and procedures.

2. Arrange and document training.

3. Oversee scheduling and notify memberclients of schedule changes.

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

5. Investigate complaints and critical incidents.

8.490.5 REIMBURSEMENT

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

8.490.5.B. Payment does not include travel time to or from the memberclient's residence.

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

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

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

1. The nature and extent of services.

2. The provider's signature.

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

8.491 ADULT DAY SERVICES

8.491.1 Definitions

Adult Day Services (ADS) Center is a certified center that provides Basic Adult Day Services and Specialized Adult Day Services to participants.

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Adult Day Services (ADS) are provided in an Adult Day Services Center or through Non-Center-Based means including Telehealth, on a regularly scheduled basis, as specified in the Person Centered Care Plan, promoting social, recreational, physical, and emotional well-being that encompasses the supportive services needed to ensure the optimal wellness of the participant.

A. Basic Adult Day Services (ADS) Center means a community-based entity that provides basic Adult Day Services in conformance with all state established requirements as described in 10 CCR 2505-10 section 8.130 and 10 CCR 2505-10 section 8.491.

B. Center-Based Adult Day Services are services provided in a certified ADS Center.

C. Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where participants can engage in activities and community life, either in-person or through virtual means.

D. Specialized Adult Day Services (SADS) Center means a community-based entity providing Adult Day Services for participants with a primary diagnosis of dementia related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington's Disease, Parkinson's, or post-stroke participants, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have a diagnosis which is one of any of the above diagnoses. Each diagnosis must be verified by a Licensed Medical Professional, either directly or through Case Management Agency documentation, in accordance with Section 8.491.14.A.

E. Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for participants to engage in activities, with their community, and connect to staff and other ADS participants virtually or over the phone, only if a participant does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services.

Care Plan means the individualized goal-oriented plan of services, supports, and preferences developed collaboratively with the participant and/or the designated or legal representative and the service provider, as outlined in 10 CCR 2505-10 8.495.6.F.

Designated Representative means a representative who is designated by the participant to act on the participant's behalf, as defined in 10 CCR 2505-10 Section 8.500.1.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 10 CCR 2505-10 8.491.4.I.

Director means any person who owns and operates an ADS Center or SADS Center or is a managing employee with delegated authority by ownership to manage, control, or perform the day-to-day tasks of operating the Center as described in 10 CCR 2505-10 Section 8.491.

Licensed Medical Professional (LMP) means a medical professional that possesses one or more of the following Colorado licenses, which must be active and in good standing: Physician, Physician Assistant, Registered Nurse (RN) or Licensed Practical Nurse (LPN) governed by the Colorado Medical License Act, and as defined in 10 CCR 2505-10 Section 8.503.

Participant means any individual found to be eligible for and enrolled in Center-Based or Non-Center-Based Adult Day Services regardless of payment source.

Provider means a service agency enrolled with the Department to provide Center-Based and/or Non-Center-Based Adult Day Services.

Qualified Medication Administration Personnel (QMAP) means an individual that has completed training, passed a competency evaluation, and is included in the Colorado Department of Public Health and

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Environment's (CDPHE) public list of individuals who have passed the requisite competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

Restraint means any physical or chemical device, application of force, or medication, which is designed or used for restricting freedom of movement, and/or modifying, altering, or controlling behavior, excluding medication prescribed by a physician as part of an ongoing treatment plan or pursuant to a diagnosis.

Staff means a paid or voluntary employee or contracted professional of the ADS Center or SADS Center.

Universal Precautions refers to a system of infection control that prevents the transmission of communicable diseases. Precautions include, but are not limited to, disinfecting of instruments, isolation and disinfection of environment, use of personal protective equipment, hand washing, and proper disposal of contaminated waste.

8.491.2 PARTICIPANT BENEFITS

8.491.2.A. Adult Day Services

1. Only participants whose needs can be met by the ADS provider within its certification category and populations served may be admitted by the ADS provider.

2. ADS shall include, but are not limited to, the following:

   a. Monitoring to ensure participants are maintaining activity levels and goals set forth in the Care Plan, pursuant to Section 8.491.4.E; and assistance with activities of daily living (ADL) as needed when ADS is provided in-person. (ADLs include but are not limited to eating, ambulation, positioning, transferring, toileting, and incontinence care).

   b. Services provided to monitor the participant's health status, monitor or administer medications (administration of medication only during the in-person delivery of services), and carry out physicians' orders as set forth in participant's individual Care Plan.

   c. Center-Based ADS must be provided in an integrated, community-based setting, which, supports participation and engagement in community life and gaining access to the greater community; participants may engage in meaningful activities in integrated and community settings.

   d. Emergency services including written procedures to meet medical crises.

   e. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.

   f. Nutrition services including therapeutic diets and snacks in accordance with the participant's individual Care Plan and hours of attendance. Nutrition services are not required during the delivery of Non-Center-Based ADS.

   g. Social and recreational supportive services as appropriate for each participant and their needs, as documented in the participant's Care Plan. Activities shall take into consideration individual differences in age, health status, sensory deficits, religious affiliation, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.

   h. Participants have the right to choose not to participate in social and recreational activities.

8.491.2.B. Adult Day Service Requirements

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1. The participant's Care Plan must include documentation of their diagnosis(es) and service goals.

2. A Specialized Adult Day Services (SADS) provider must verify all Medicaid participant's diagnosis(es) using the Professional Medical Information Page (PMIP) which shall be supplied by the case manager or documentation from the participant's Licensed Medical Professional (LMP). Documentation must be verified at the time of admission and whenever there is a significant change in the participant's condition. Any significant change must be recorded in the participant's record or Care Plan.

   a. For participants from other payment sources, diagnosis(es) must be documented in a care plan, or other admission form, and verified by the participant's physician or LMP. This documentation must be verified at the time of admission, and whenever there is a significant change in the participant's condition.

8.491.3 PROVIDER REQUIREMENTS

A. General

1. ADS providers shall conform to all provider participation requirements, as defined in 10 CCR 2505-10 Section 8.130. ADS Centers shall have in effect all required licenses, certifications, and insurance, as applicable. ADS Center providers shall comply with ADS Center regulations and Life Safety Code (LCS) regulations, as determined by the Colorado Division of Fire Protection and Control.

2. ADS providers shall be Medicaid certified by the Department as an ADS provider, in accordance with 10 CCR, 2505-10 Section 8.487.20. Proof of Medicaid certification consists of a completed Provider Agreement approved by the Department and the Department's fiscal agent, and recommendation for certification by CDPHE.

   a. Certification shall be denied, revoked, suspended, or terminated when a Provider is unable to meet, or adequately correct deficiencies relating to, certification standards as defined at 10 CCR 2505-10 section 8.491.

3. The Department or its designee will review an ADS Center's designation as a Specialized Adult Day Services (SADS) Center at the time of initial approval and during the recertification survey.

4. Denial, termination, or non-renewal of the Provider Agreement shall be for "Good Cause" as defined in 10 CCR 2505-10 section 8.076.

5. All providers of ADS shall operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation and other standards prescribed in law or regulations. This includes certification of building use occupancy.

8.491.4 PROVIDER ROLES AND RESPONSIBILITIES

A. Environment

1. All ADS providers must comply with the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings Final Rule requirements, 42 C.F.R. § 441.301(c)(4). This includes:

   a. ADS Center must be integrated in and supports full access of individuals to the greater community;

   b. ADS provider is selected by the individual from among setting options including non-disability specific settings;

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c. ADS provider ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;

d. ADS provider optimizes individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact; and

e. ADS provider facilitates individual choice regarding services and supports, and who provides them.

2. ADS Centers presumed to have institutional qualities will be subject to heightened scrutiny and reviewed by the Department and CMS, per 42 C.F.R. § 441.301(a)(2)(v). Settings in which this may apply include but are not limited to those where:

a. The provision of inpatient institutional treatment within a publicly or privately-operated facility happens within the same building.

b. Located on the grounds of, or adjacent to, a public institution.

c. The effect of isolating participants receiving Medicaid Home and Community Based Services (HCBS) from the broader community.

2. If an ADS Center is subject to heightened scrutiny, Medicaid reimbursement by the Department may not be issued if the center fails CMS's heightened scrutiny review or until CMS approves the center.

3. ADS Centers shall provide a clean and sanitary environment that is free of obstacles that could pose a hazard to participant health and safety, allowing individuals the freedom to safely move about inside and outside the ADS Center.

4. ADS Centers shall provide lockers or a safe and secure place for participants' personal items.

5. ADS Centers shall provide recreational areas and recreational activities appropriate to the number and needs of the participants, at the times desired by the participants.

6. ADS Centers shall ensure the following are physically accessible to the participants at all times during hours of operation:

a. Access to drinking water and other beverages;

b. Bathrooms, sinks, and paper towel dispensers or hand dryers;

c. Appliances and equipment used by or in the delivery of activities offered by the ADS Center, such as, tables/desks and chairs at a convenient height and location; and

d. Free from obstructions such as steps, lips in doorways, narrow hallways, limiting individuals' mobility in the ADS Center. If obstructions are present, environmental adaptations are to be made to allow for participant access.

7. ADS Centers must provide for a private shower and/or bathing area located on site to address the emergency hygiene needs of participants as needed.

8. To accommodate the activities and program needs of the ADS Center, the center must provide eating and activity areas that are consistent with the number and needs of the participants being served, which is at a minimum of 40 square feet per participant.

9. ADS Centers shall maintain a comfortable temperature throughout the center. At no time shall the temperature fall outside the range of 68 degrees to 76 degrees Fahrenheit.

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10. ADS Centers must provide an environment free from restraints.

11. ADS Centers, in accordance with 10 CCR 2505-10 section 8.491.4.A above, must provide a safe environment for all participants, including participants exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

B. Food Safety Requirements

1. ADS providers shall comply with all applicable local food safety regulations. In addition, all ADS Centers must ensure:

a. Access to a handwashing sink, soap and disposable paper towels;

b. Food handlers, cooks and servers, including participants engaged in food preparation, properly wash their hands using proper hand-washing guidelines;

c. The ADS Centers do not allow any staff or participants who are not in good health and free of communicable disease to handle, prepare or serve food or handle utensils;

d. Refrigerated foods opened or prepared and not used within 24 hours are marked with a "use by" or "discard by" date. The "use by" or "discard by" date may not exceed 7 days following opening or preparation, or exceed or surpass the manufacturer's expiration date for the product or its ingredients;

e. For food service, foods are maintained at the proper temperatures at all times. Foods that are stored cold must be held at or below 41 degrees Fahrenheit and foods that are stored hot must be held at or above 135 degrees Fahrenheit in order to control the growth of harmful bacteria;

f. Kitchen and food preparation equipment are maintained in working order and cleanable; and

g. Any equipment or surfaces used in the preparation and service of food are washed, rinsed and sanitized before use or at least every 4 hours of continual use. Dish detergent must be labeled for its intended purpose. Sanitizer must be approved for use as a no-rinse food contact sanitizer. Sanitizers must be registered with the Environmental Protection Agency (EPA) and used in accordance with labeled instructions.

C. Medication Administration and Monitoring

1. All medications shall be administered by Qualified Medication Administration Personnel (QMAP) staff, LMP staff or self-administered, regardless of the location where services are rendered.

2. Center-Based and Non-Center-Based ADS providers shall require each staff person who administers medication, that is not a LMP, to have completed training, passed a competency evaluation and be included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the QMAP competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

3. All medication, when stored and administered by the ADS provider, shall be stored in a locked cabinet when unattended by QMAP or LMP staff.

4. Non-prescription medications, when stored by the ADS provider, shall be labeled with the recipient's name, and shall not be taken by any other participants.

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5. A QMAP shall not conduct feeding or administer medication through a gastrostomy tube or administer intravenous, intramuscular or subcutaneous injections.

D. Records and Information

1. All ADS providers shall keep records and information necessary to document the services provided to participants receiving Adult Day Services. Records shall include but not be limited to:

a. Name, address, gender, and date of birth of each participant;

b. Name, address and telephone number of designated representative and/or emergency contact;

c. Name, address and telephone number of primary physician;

d. Documentation of the supervision and monitoring of services provided;

e. Documentation that all participants and their designated representatives (if any) were oriented to the ADS Center, their policies and procedures, to the services provided by the ADS provider, and delivery methods offered.;

f. A service agreement signed by the participant and/or the designated representative and appropriate staff; and

g. For SADS providers only, a copy of the PMIP, or diagnosis documentation from the participant's LMP;

h. Documentation specifically stating the types of services and monitoring that are provided when rendered via Telehealth, ensuring the integrity of the service provided and the benefit the service provides the participant.

E. Care Plan

1. The following information must be documented in the Care Plan and used to direct the participant's care and must be reviewed annually.

a. Medical Information:

i. All medications the participant is taking, including those while receiving Center-Based or Non-Center-Based ADS, and whether they are being self-administered;

ii. Special dietary considerations, instructions, or restrictions;

iii. Services that are administered to the participant while receiving Center-Based and/or Non-Center-Based ADS (may include nursing or medical interventions, speech therapy, physical therapy, or occupational therapy);

iv. Any restrictions on social and/or recreational activities identified by participant's LMP; and

v. Any other special health or behavioral management services or supports recommended to assist the participant by the participant's LMP.

b. Care Planning Documentation:

i. Documentation that the provider was selected by the individual and/or designated representative or legal representative;

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ii. Individual choices, including location and delivery method for ADS, preferences, and needs shall be incorporated into the goals and services outlined in the Care Plan;

iii. All participant information and the Care Plan are considered protected health information and shall be kept confidential; and

iv. Participant and/or designated representative or legal representative must review and sign the Care Plan.

c. Modifications to the Care Plan must be supported by a specific and assessed need. Informed consent and proper documentation in the Care Plan are required for any changes including but not limited to:

i. Identification of the specific and individualized assessed need; and

ii. Documentation of any intervention and/or additional supports offered to support the participant appropriately.

d. Documentation that the participant and/or designated representative was provided with written information about the participant's right to establish an advance directive.

e. Documentation as to whether the participant has executed an advance directive or other declaration regarding medical decisions. Such documentation shall be maintained in the participant's record.

f. All entries into the record shall be legible, written in ink, dated, and signed with name and title designation, or records shall be maintained electronically with electronic signatures in accordance with standards for electronic medical record keeping practices.

F. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:

a. Death;

b. Abuse/neglect/exploitation;

c. Serious injury to participant or illness of participant;

c. Damage or theft of participant's property;

d. Medication mismanagement;

e. Lost or missing person; and

f. Criminal activity.

2. A provider must submit a verbal or written report of a Critical Incident to the HCBS participant's Case Management Agency (CMA) case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

a. Participant name;

b. Participant Medicaid identification number;

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c. Waiver;

d. Incident type;

e. Date and time of incident;

f. Location of incident;

g. Persons involved;

h. Description of incident; and

i. Resolution, if applicable.

3. If any of the above information is not available within 24 hours of incident and not reported to the CMA case manager, a follow-up to the initial report must be completed.

G. Staff Requirements

1. In determining appropriate staffing levels, the ADS provider shall adjust staffing ratios based on the individual acuity and needs of the participants being served. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition of Direct Care Staff defined at 10 CCR 2505-10, Sections 8.491.1. Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

a. Staffing for Center-Based and in person Non-Center-Based ADS shall be no less than the following standard:

i. A minimum of 1 staff to 8 participants with continuous supervision of participants during program operation.

b. Staffing for Telehealth ADS shall be no less than the following standard:

i. A minimum of 1 staff to 15 virtual participants with continuous virtual supervision of participants during Telehealth program operation.

c. Staff shall provide the following:

i. Immediate response to emergency situations to assure the safety, health and welfare of participants;

ii. Activities that are planned to support the plans of care for the participants; and

iii. Administrative, recreational, social, and supportive functions and duties.

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d. Nursing services for regular monitoring of the on-going medical needs of participants and the supervision of medications. These services must be available a minimum of two hours daily during Center-Based ADS, and as needed for Non-Center-Based ADS, and must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Certified Nursing Assistant's (CNA) may provide nursing services under the direction of a RN or an LPN, in conformance with nurse delegation provisions outlined in CRS 12-38-132. Supervision of CNAs must include documented consultation and oversight on a weekly basis or more according to the participant's needs. If the supervising RN or LPN is an ADS provider staff member, with consultation and oversight of CNAs included in the member's job description, the supervising nurse's documented attendance shall be sufficient to document consultation and oversight.

2. In addition to the above services, Specialized Adult Day Services (SADS) Centers shall have sufficient staff to provide nursing services during all hours of operation.

a. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 10 CCR 2505-10 section 8.491.4.G.1.e above and employed or contracted by the SADS Center.

3. The ADS provider shall require any individual seeking employment with that agency to submit to a criminal history record check to ascertain whether the individual seeking employment has been convicted of a felony or misdemeanor that involves conduct that the provider determines could pose a risk to the health, safety or welfare of participants.

4. The criminal history record check shall, at a minimum, include a search of criminal history in the State of Colorado and be conducted not more than 90 days prior to employment of the individual.

5. In assessing whether to employ an applicant with a felony or misdemeanor conviction, the ADS provider shall consider the following factors:

a. The history of convictions, pleas of guilty or no contest,

b. The nature and seriousness of the crimes;

c. The time that has elapsed since the conviction(s);

d. Whether there are any mitigating circumstances; and

e. The nature of the position for which the applicant would be employed.

6. The ADS provider shall develop and implement policies and procedures regarding the employment of any individual who is convicted of a felony or misdemeanor to ensure that the individual does not pose a risk to the health, safety and welfare of the consumer.

H. Director Qualifications

1. All Directors hired or designated after January 1, 2019, shall meet one of the following qualifications:

a. At least a bachelor's degree from an accredited college or university and a minimum of two years of social services or health services experience and shall have demonstrated ability to perform all aspects of the position; or

b. A licensure by the state of Colorado as a Licensed Practical Nurse or Registered Nurse and completion of two years of paid or volunteer experience in planning or delivering health or social services including experience in supervision and administration; or

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c. A high school diploma or GED equivalent, a minimum of four years of experience in a social services or health services setting, skills to work with aging adults or adults with functional impairment, and skills to supervise ADS Center staff persons.

I. Training Requirements

1. All ADS staff and volunteers must be trained in the ADS provider's programmatic policies and procedures.

2. ADS providers providing medication administration as a service must have QMAP staff qualified in accordance with C.R.S. 6 CCR 1011-1 Chapter 24, unless medications are administered only by LMPs.

3. All staff and volunteers must be trained in the use of universal precautions and infection control, as defined at 10 CCR 2505-10 section 8.491.1.

4. The ADS Director and staff must receive training specific to the needs and diagnoses of the participants served. Training may include, but is not limited to: behavioral expression and management techniques, effective communication techniques, redirection, cardiopulmonary resuscitation, validation theory and communication, seizure response, and brain injuries.

a. Documentation of staff member and Director trainings must include, but is not limited to: training provided, who completed trainings, who conducted trainings, and completion date.

5. All ADS staff must be trained in the handling of emergency services including written procedures to meet medical crises, and natural and manmade disasters.

6. All required training must be documented, and documentation must be maintained in individual staff's personnel files. Each staff person's training must be up-to-date.

J. Dementia Training Requirements

1. As of October 1, 2023, each Adult Day Services provider shall ensure that its Direct-Care Staff Members complete dementia training as required by Section 25.5-6-314, C.R.S.

2. Definitions applicable to Dementia Training Requirements:

a. "Covered Facility" means a Assisted Living Residences, Nursing Care Facilities, and Adult Day Care Facilities as defined in Section 25.5-6-303(1), C.R.S.

b. "Dementia diseases and related disabilities" is a condition where mental ability declines and is severe enough to interfere with an individual's ability to perform everyday tasks. Dementia diseases and related disabilities include Alzheimer's disease, mixed dementia, Lewy Body Dementia, vascular dementia, frontotemporal dementia, and other types of dementia.

c. "Direct-Care Staff Member" means a staff member caring for the physical, emotional, or mental health needs of participants of an Adult Day Services provider and whose work involves regular contact with participants who are living with Dementia Diseases and related disabilities.

d. "Staff member" means an individual, other than a volunteer, who is employed by an Adult Day Services provider.

e. "Equivalent training" means any initial training provided by a Covered Facility that meets the requirements in Section 8.491.4.J.3.

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3. Initial training: Each Adult Day Services provider is responsible for ensuring that all Direct-Care Staff Members are trained in dementia diseases and related disabilities.

a. Initial training shall be available to Direct-Care Staff Members at no cost to them.

b. The training shall be competency-based and culturally competent and shall include a minimum of four hours of training in dementia topics including the following content:

1) Dementia diseases and related disabilities;

2) Person-centered care;

3) Care planning;

4) Activities of daily living; and

5) Dementia-related behaviors and communication.

c. For Direct-Care Staff Members already employed prior to October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after October 1, 2023, unless an exception, as described in Section 8.491.4.J.4.a, applies.

d. For Direct-Care Staff Members hired or providing care on or after October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after the start of employment or the provision of direct-care services, unless an exception, as described in Section 8.491.4.J.4.b, applies.

4. Exception to initial dementia training requirement

a. Any Direct-Care Staff Member who is employed by or providing direct-care services prior to the October 1, 2023, may be exempted from the provider's initial training requirement if all of the following conditions are met:

1) The Direct-Care Staff Member has completed Equivalent Training program, as defined in these rules, within the 24 months immediately preceding October 1, 2023; and

2) The Direct-Care Staff Member can provide documentation of the satisfactory completion of the Equivalent Training program.

3) If the Equivalent Training was provided more than 24 months prior to the date of hire, the individual must document participation in both the Equivalent Training and all required continuing education subsequent to the initial training.

b. Any Direct-Care Staff Member who is hired or begins providing direct-care services on or after October 1 ,2023, may be exempted from the provider's initial training requirement if the Direct-Care Staff Member:

1) Has completed an equivalent initial dementia training program, as defined in these rules, either:

a) Within the 24 months immediately preceding October 1, 2023; or

b) Within the 24 months immediately preceding the date of hire or the first date the Direct-Care Staff Member provides direct care services; and

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2) Provides documentation of the satisfactory completion of the initial training program; and

3) Provides documentation of all required continuing education subsequent to the initial training.

c. Such exceptions shall not exempt a Direct-Care Staff Member from the requirement for dementia training continuing education as described in Section 8.491.4.J.5.

5. Dementia Training: Continuing Education

a. After completing the required initial training, all Direct-Care Staff Members shall have completed and documented a minimum of two hours of continuing education on dementia topics every two years.

b. Continuing education on this topic must be available to Direct-Care Staff Members at no cost to them.

c. This continuing education shall be culturally competent, include current information provided by recognized experts, agencies, or academic institutions, and include best practices in the treatment and care of persons living with dementia diseases and related disabilities.

6. Individuals conducting dementia training must meet the following minimum requirements:

a. Specialized training from recognized experts, agencies, or academic institutions in dementia disease, or

b. Successful completion of training which meets the minimum standards described herein; and

c. Two or more years of experience working with persons living with dementia diseases and related disabilities.

7. Documentation of initial dementia training and continuing education for Direct-Care Staff Members:

a. The provider shall maintain documentation that each Direct-Care Staff Member has completed initial dementia training and continuing education. Such records shall be made available upon request.

b. Completion shall be demonstrated by a certificate, attendance roster, or other documentation.

c. Documentation shall include the number of hours of training, the date on which it was received, and the name of the instructor and/or training entity.

d. Documentation of the satisfactory completion of an equivalent initial training program as defined in Section 8.491.4.J.2.e. shall include the information required in this Section 8.491.4.J.7.b. & c.

e. After the completion of training and upon request, such documentation shall be provided to the staff member for the purpose of employment at another Covered Facility.

K. Written Policies

1. The ADS provider shall have written policies and procedures relevant to its operation. Such policies shall include, but not be limited to, statements describing:

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a. Admission criteria for participants who can be appropriately served by the ADS provider;

b. Intake procedures conducted for participants and/or designated representatives prior to admission with the ADS provider;

c. The meals and nourishments including special diets that are provided;

d. The hours and days that Center-Based ADS are open and available, and the days and times that Non-Center Based ADS are available to participants, including the availability of nursing services;

e. Medication administration and storage;

f. The personal items that the participants may bring with them to the ADS Center;

g. Emergency services including written procedures to meet medical crises, and natural and manmade disasters; and

h. The administration of Telehealth Adult Day Services, if provided. This includes telehealth options, provision of services, and examples of virtually offered services.

2. There shall be a written, signed agreement between the participant and/or designated representative and the ADS provider outlining the rules and responsibilities of the ADS provider and the participant. Each party in the agreement shall be provided a copy.

L. Exclusions

1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS and therefore are not reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.

8.491.5 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

A. Reimbursement for ADS for participants in the HCBS Elderly, Blind and Disabled (EBD) waiver, Community Mental Health Supports waiver (CMHS), and the Spinal Cord Injury (SCI) waiver is to be billed in accordance with the current rate schedule:

1. Providers may bill in 15-minute units or for 1-2 units of 3-5-hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 12 units or three (3) hours per day of Basic Adult Day Services. A provider may bill the maximum of 15-minute units for ADS in combination with no more than 1 unit of 3-5 hour ADS on the same day, as long as services were rendered at separate times.

B. For persons in the HCBS waiver for Persons with a Brain Injury (BI), reimbursement for BI-ADS is to be billed in accordance with the current rate schedule.

1. A unit is defined as the following:

a. Providers may bill in units of 15 minutes or a unit of 2 or more hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 8 units or two (2) hours per day of services. Units of 2 hours or more can only be delivered in-person. A provider cannot bill for 15-minute units of ADS if a unit of 2-hour BI ADS was provided on the same day.

C. ADS Centers are permitted to utilize funding from other Federal sources, such as the Child and Adult Care Food Program (CACFP), in addition to the Medicaid per diem. If such funding is utilized, a

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Center must acknowledge the use of multiple funding sources and demonstrate that Federal funds are not used in a duplicative manner to Medicaid-funded services.

D. Only providers certified as a Specialized Adult Day Services Center are permitted to receive the SADS reimbursement rate, for participants needing SADS. The SADS reimbursement rate applies to every participant at a SADS Center, even if the participant does not have a specialized diagnosis.

E. Certified SADS providers may provide Non-Center-Based Adult Day Services, including Telehealth ADS, billing only for Basic Adult Day Services using the 15-minute unit, up to 3 hours per day. The SADS provider may bill the maximum of 15-minute units for Basic ADS in combination with no more than 1 unit of 3-5 hour SADS on the same day, as long as services were rendered at separate times.

F. Providers shall not bill for services on the same day of service for a participant in an HCBS residential program, unless the following criteria have been met:

1. ADS and residential services have been authorized by the Department and are included on the prior authorization request (PAR);

2. Participant's diagnoses must meet the criteria for a SADS Center;

3. Documentation from the participant's physician demonstrating the required specialized services in the SADS Center are necessary because of the qualifying diagnosis(es), are essential to the care of the participant, and are not included in the residential per diem;

4. Documentation that the extensive rehabilitative therapies and therapeutic needs of the participant are not being met by the residential program and are not included in the residential per diem; and

5. Documentation from the participant's physician recommending SADS and how it will meet the previously mentioned needs.

8.492 RESPITE CARE

8.492.10 DEFINITIONS

.11 Respite care means services provided to an eligible memberclient on a short-term basis because of the absence or need for relief of those persons normally providing the care.

.12 Respite care provider means a Class I nursing facility, an alternative care facility, or respite care provided in a residence by an employee of a certified personal care agency which meets the certification standards for respite care specified below.

8.492.20 INCLUSIONS

.21 A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite memberclient, as ordered by the physician.

.22 An alternative care facility shall provide all the alternative care facility services as listed at 10 CCR 2505-10 section 8.495, which are required by the individual respite memberclient.

8.492.30 RESTRICTIONS

.31 An individual memberclient shall be authorized for no more than thirty (30) days of respite care in each certification period unless otherwise authorized by the Department.

.32 Alternative care facilities shall not admit individuals for respite care who are not appropriate for alternative care facility placement, as specified at 10 CCR 2505-10 section 8.495.

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.33 Only those portions of the facility that are Medicaid certified for nursing facility or alternative care facility services may be utilized for respite memberclients.

8.492.40 CERTIFICATION STANDARDS AND PROCEDURES

.41 Respite care standards and procedures for nursing facilities are as follows:

A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

B. The nursing facility does not have to maintain or hold open separately designated beds for respite memberclients, but may accept respite memberclients on a bed available basis.

C. For each HCBS-EBD respite memberclient, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the memberclient. The chart must identify the memberclient as a respite memberclient. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

D. An admission to a nursing facility under HCBS-EBD respite does not require a new ULTC-100.2, a PASRR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or labwork as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

E. The nursing facility shall have written policies and procedures available to staff regarding respite care memberclients. Such policies could include copies of these respite rules, the facility's policy regarding self administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care memberclients.

F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite memberclient's entry into the facility.

.42 Respite care standards and procedures for alternative care facilities are as follows:

A. The alternative care facility shall have a valid contract with the Department as a Medicaid certified HCBS-EBD alternative care facility provider. Such contract shall constitute automatic certification for HCBS-EBD respite care.

B. For each respite care memberclient, the alternative care facility shall follow normal procedures for care planning and documentation of services rendered.

.43 Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

8.492.50 REIMBURSEMENT

.51 Respite care reimbursement to nursing facilities shall be as follows:

A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-EBD claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

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C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

.52 Respite care reimbursement to alternative care facilities shall be as follows:

A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-EBD claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

.53 Individual respite providers shall bill according to a unit rate or daily institutional Nursing Facility rate, whichever is less.

.54 The respite care provider shall provide all the respite care that is needed, and other HCBS-EBD services shall not be reimbursed during the respite stay.

.55 There shall be no reimbursement provided under this section for respite care in uncertified congregate facilities.

8.493 HOME MODIFICATION

8.493.1 DEFINITIONS

Case Management Agency (CMA) means an agency within a designated service area where an applicant or memberclient can obtain Case Management services. CMAs include Single Entry Points (SEP), Community Centered Boards (CCB), and private case management agencies.

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

Department means the Department of Health Care Policy and Financing.

The Division of Housing (DOH) is a State entity within the Department of Local Affairs that is responsible for approving Home Modification PARs, oversight on the quality of Home Modification projects, and inspecting Home Modification projects, as described in 10 CCR 2505-10 section 8.493.

Eligible MemberClient means a memberclient who is enrolled in the following Home and Community-Based Services (HCBS) waivers: Brain Injury, Spinal Cord Injury, Community Mental Health Supports, or Elderly, Blind and Disabled.

Home Modification means specific modifications, adaptations or improvements in an Eligible MemberClient's existing home setting which, based on the memberclient's medical condition:

1. Are necessary to ensure the health, welfare and safety of the memberclient, and

2. Enable the memberclient to function with greater independence in the home, and

3. Are required because of the memberclient's illness, impairment or disability, as documented on the ULTC-100.2 form and the care plan; and

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4. Prevents institutionalization or supports the deinstitutionalization of the memberclient.

Home Modification Provider means a provider agency that has met all the standards for Home Modification described in 10 CCR 2505-10 section 8.493.5.B and is an enrolled Medicaid provider.

Person-Centered Planning as applies to Home Modifications means that Home Modifications shall be agreed upon through a process that is driven by the individual memberclient and can include people chosen by the memberclient, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations. The home modification process provides necessary information, support, and choice to the memberclient to ensure that the memberclient directs the process to the maximum extent possible. MemberClient choice shall be documented throughout according to Department prescribed processes and procedures.

8.493.2 BENEFITS

8.493.2.A. Home Modifications, adaptations, or improvements may include but are not limited to the following:

1. Installing or building ramps.

2. Installing grab-bars and installing other Durable Medical Equipment (DME) project if such installation cannot be performed by a DME supplier.

3. Widening doorways.

4. Modifying bathrooms.

5. Modifying kitchen facilities.

6. Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies.

7. Installing stair lifts or vertical platform lifts.

8. Modifying an existing second exit or egress window for emergency purposes.

a. The modification of a second exit or egress window must be approved by the Department or its agent as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the memberclient.

8.493.2.B. Previously completed home modifications, regardless of original funding source, shall be eligible for maintenance or repair within the memberclient's remaining lifetime cap while remaining subject to 8.493.3, Exceptions and Restrictions.

8.493.2.C. There shall be a lifetime cap of $14,000 per memberclient. The Department may authorize funds in excess of the memberclient's lifetime cap if there is:

1. An immediate risk of the memberclient being institutionalized; or

2. A significant change in the memberclient's needs since a previous home modification.

8.493.3 EXCEPTIONS AND RESTRICTIONS

8.493.3.A. Home Modifications must be a direct benefit to the memberclient as defined in 10 CCR 2505-10 Section 8.493.1 and not for the benefit or convenience of caregivers, family members, or other residents of the home.

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8.493.3.B. Duplicate adaptations, improvements, or modifications are not a benefit. This includes, but is not limited to, multiple bathrooms within the same home.

8.493.3.C. Adaptations, improvements, or modifications as a part of new construction costs are not a benefit.

8.493.3.D. The purchase of Durable Medical Equipment (DME) is not a benefit.

8.493.3.E. The Department may deny requests for Home Modification projects that exceed usual and customary charges or do not meet local building requirements, the LTSS Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The LTSS Home Modification Benefit Construction Specifications (2016) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2016 LTSS Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to §24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.493.3.F. Home Modification projects are not a benefit in any type of certified or non-certified congregate facility, as defined in 10 CCR 2505-10 Section 8.485.50.F and G.

8.493.3.G. Volunteer work on a Home Modification project approved by the Department shall be completed under the supervision of the Home Modification Provider as stated on the bid.

1. Volunteer work performed by Department-approved organizations must be described according to Department prescribed processes and procedures. A list of these organizations can be found on the Department website.

2. Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family member, or work performed by a private contractor hired by the memberclient or family, must be described and agreed upon, in writing, by the provider responsible for completing the home modification, according to Department prescribed processes and procedures.

8.493.3.H. If a memberclient lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by the Fair Housing Act, the memberclient's Home Modification funds may not be used unless reasonable accommodations have been denied. The Fair Housing Act (42 U.S.C. § 3601, et seq.)(1995) is hereby incorporated by reference. The incorporation of this Act excludes later amendments to, or editions of, the referenced material. Pursuant to §24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.493.4 CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.493.4.A. The Case Manager shall consider alternative funding sources to complete the Home Modification, including, but not restricted to those sources identified and recommended by the Department and DOH on the Department website. These alternatives and the reason they are not available shall be documented in the case record.

1. The Case Manager must confirm that the memberclient is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by the Fair Housing Act.

8.493.4.B. The Case Manager may approve Home Modification projects estimated at less than $2,500 without prior authorization, contingent on memberclient authorization and confirmation of Home Modification fund availability.

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8.493.4.C. The Case Manager shall obtain prior approval by submitting a Prior Authorization request form (PAR) to the Department for Home Modification projects estimated at between $2,500 and $14,000.

1. The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures. Home Modifications submitted with improper documentation are not authorized.

2. The Case Manager and CMA are responsible for retaining and tracking all documentation related to a memberclient's home modification lifetime cap use and communicating that information to the memberclient and providers. The Case Manager may request confirmation of a memberclient's home modification lifetime cap use from the Department, its fiscal agent, or DOH.

8.493.4.D. Home Modifications estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1. An occupational or physical therapist (OT/PT) shall assess the memberclient's needs and the therapeutic value of the requested Home Modification. When an OT/PT with experience in Home Modification is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Modification would contribute to a memberclient's ability to remain in or return to his/her home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

2. The evaluation services may be provided by a home health agency or other qualified and approved OT/PT through Medicaid Home Health consistent with Home Health rules set forth in Section 8.520, including physician orders and plans of care.

a. A Case Manager may initiate the OT/PT evaluation process before the memberclient has been approved for waiver services, as long as the memberclient is Medicaid eligible.

b. A Case Manager may initiate the OT/PT evaluation process before the memberclient physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

3. The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the memberclient's needs. The Case Manager shall document these alternatives in the memberclient's case file.

8.493.4.E. The Case Manager shall solicit bids according to the following procedures:

1. The Case Manager shall solicit bids from at least two Home Modification Providers.

a. The Case Manager must verify that the provider is an enrolled Home Modification Provider.

b. The bids must be submitted according to Department prescribed processes and procedures as found on the Department website.

2. The bids shall include a breakdown of the costs of the project including:

a. Description of the work to be completed.

b. Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.

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c. Estimate for building permits, if needed.

d. Estimated timeline for completing the project.

e. Name, address and telephone number of the Home Modification Provider.

f. Signature, including option for digital signature, of the Home Modification Provider.

g. Signature, including option for digital signature, of the memberclient or other indication of approval.

h. Signature, including option for digital signature, of the homeowner or property manager if applicable.

3. Home Modification Providers have a maximum of thirty (30) days to submit a bid for the Home Modification project after the Case Manager has solicited the bid.

a. If the Case Manager has made three attempts to obtain a written bid from a Home Modification Provider and the Home Modification Provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

5. The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements of Section 8.493 and the recommendations of the OT/PT evaluation.

a. If a memberclient or homeowner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

6. A revised PAR and Change Order request shall be submitted according to the procedures outlined in this section for any changes from the original approved PAR according to Department prescribed processes and procedures.

8.493.4.F. If a property to be modified is not owned by the memberclient, the Case Manager shall obtain signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein. Signatures may be completed using a digital signature based on preference of the individual signing the form.

1. Written consent of the homeowner or property manager, as evidenced by the above-mentioned signatures, is required for all projects that involve permanent installation within the memberclient's residence or installation or modification of any equipment in a common or exterior area.

2. If the memberclient vacates the property, these signatures evidence that the homeowner or property manager agrees to allow the memberclient to leave the modification in place or remove the modification as the memberclient chooses. If the memberclient chooses to remove the modification, the property must be left equivalent or better to its pre-modified condition. The homeowner or property manager may not hold any party responsible for removing all or part of a home modification project.

8.493.4.G. If the CMA does not comply with the process described above resulting in increased cost for a home modification, the Department may hold the CMA financially liable for the increased cost.

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8.493.4.H. The Department or its agent may conduct on-site visits, or any other investigations deemed necessary prior to approving or denying the Home Modification request.

8.493.5 PROVIDER RESPONSIBILITIES

8.493.5.A. Home Modification Providers shall conform to all general certification standards and procedures set forth in 10 CCR 2505-10 section 8.487.11.

8.493.5.B. Home Modification Providers shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county.

8.493.5.C. Home Modification Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including memberclient notification. Reimbursement may be reduced for delays in accordance with Section 8.493.6.F.

1. If any changes to the approved scope of work are made without Department authorization, the cost of those changes will not be reimbursed.

2. Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including memberclient notification. Reimbursement may be reduced for delays in accordance with Section 8.493.6.F.

8.493.5.D. The Home Modification Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at their expense.

8.493.5.E. The Home Modification Provider shall comply with the LTSS Home Modification Benefit Construction Specifications developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8.493.5.F. All Home Modification projects within a Department-established sampling threshold shall be inspected upon completion by DOH, a state, local or county building inspector or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Modification projects may be inspected by DOH upon request by the memberclient at any time determined to be reasonable by DOH or the Department. MemberClients must provide access for inspections.

1. DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion or receipt of a memberclient's reasonable request.

2. DOH shall produce a written inspection report within three (3) days of performing an inspection that notes the memberclient's specific complaints. The inspection report shall be sent to the memberclient, Case Manager, and provider.

3. Home Modification providers must repair or correct any noted deficiencies within twenty (20) days or the time required by the inspection, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including memberclient notification. Reimbursement may be reduced for delays in accordance with Section 8.493.6.D.

8.493.5.G. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Modification Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be justification for recovery of payment by the Department.

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8.493.6 REIMBURSEMENT

8.493.6.A. Payment for Home Modification services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two payments per Home Modification.

8.493.6.B. The Home Modification Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8.493.6.C. The Home Modification Provider may submit a claim for final payment when the Home Modification project has been completed satisfactorily as shown by the submission of the documentation below to DOH:

1. Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2. Required permits;

3. One year written warranty on materials and labor; and

4. Documentation in the memberclient's file that the Home Modification has been completed satisfactorily through:

a. Receipt of inspection report approving work from the building inspector or other inspector as referenced at 10 C.C.R. 2505-10, Section 8.493.5.F;

b. Approval by the memberclient, representative, or other designee;

c. Approval by the home owner or property manager;

d. By conducting an on-site inspection; or

e. DOH acceptance of photographs taken both before and after the Home Modification.

8.493.6.D. If DOH notifies a Home Modification Provider that an additional inspection is required, the Home Modification Provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8.493.6.E. The Home Modification Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Modification Provider Bid form or Home Modification Provider Change Order form.

1. All recommended repairs noted on inspections shall be completed before the Home Modification Provider submits a final claim for reimbursement.

2. If a Home Modification Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the Provider during an inspection. The Provider shall only be reimbursed for the value of the work completed satisfactorily.

a. A Home Modification Provider may request DOH perform one (1) redetermination of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the Provider's expense.

8.493.6.F. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies inspection deficiencies.

1. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including memberclient notification.

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2. The home modification reimbursement reduced pursuant to this subsection shall be incorporated into the computation of the memberclient's remaining lifetime cap.

8.493.6.G. The Home Modification Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the memberclient. The Home Modification Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the memberclient's DME benefit.

8.494 NON-MEDICAL TRANSPORTATION

8.494.1 DEFINITIONS

Non-Medical Transportation (NMT) services means transportation which enables eligible participants to gain physical access to non-medical community services and supports, as required by the care plan to prevent institutionalization.

Non-Medical Transportation Provider (provider) means a provider agency that has met all standards and requirements as specified in Section 8.494.40 of this regulation.

8.494.20 INCLUSIONS

.21 Non-Medical Transportation services shall include, but not be limited to, transportation between the participant's home and non-medical services or supports such as Adult Day Centers, shopping, activities that encourage community integration, therapeutic swimming, counseling sessions not covered by State Plan, and other services as required by the care plan to prevent institutionalization.

8.494.30 EXCLUSIONS

.31 Non-Medical Transportation services shall not be used to substitute for medical transportation, as defined in Section 8.014.1.

.32 Non-Medical Transportation services shall only be used after the case manager has determined that free transportation is not available to the participant.

8.494.40 PROVIDER STANDARDS FOR NON-MEDICAL TRANSPORTATION SERVICES

.41 Providers shall conform to all general standards and procedures set forth within Department regulations Sections 8.494 and 8.487.

.42 Providers must maintain liability insurance with the following automobile liability minimum limits:

A. Bodily injury (BI) $300/$600K per person/per accident; and

B. Property damage $50,000.

C. Drivers that utilize their personal vehicle on behalf of a provider agency to provide NMT must maintain the following minimum automobile insurance limits, in addition to the insurance maintained by the provider agency:

1. Bodily injury (BI) $25/$50K per person/per accident; and

2. Property damage $15,000.

.43 Providers shall ensure that each driver rendering NMT meets the following requirements:

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A. Drivers must be 18 years of age or older to render services;

B. Have at least one year of driving experience;

C. Possess a valid Colorado driver's license;

D. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history; and

E. Complete a Colorado or National-based criminal history record check.

.44 Drivers shall be disqualified from serving as drivers for any program participants for any of the following:

A. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;

B. A conviction in the State of Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;

C. A conviction in the State of Colorado, within the seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);

D. A conviction in the State of Colorado, within the four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15 of Title 18, C.R.S.;

E. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D) within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6114;

F. A conviction in the State of Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;

G. A conviction in Colorado within the two (2) years preceding the date the criminal history record check is completed of driving under the influence, as defined in § 42-4-1301(1)(f), C.R.S.; driving with excessive alcoholic content, as described in §42-4-1301(1)(g), C.R.S;

H. A conviction within the two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B), 4 C.C.R. 723-6; § 6114 in any other state or in the United States; and

For purposes of 4 C.C.R. 723-6; § 6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sentence.

.45 Vehicles used during the provision of NMT must be safe and in good working order. To ensure the safety and proper functioning of the vehicles, vehicles must pass a vehicle safety inspection prior to it being used to render services.

A. Safety inspections shall include the inspection of items as described in Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6104.

B. Vehicles must be inspected on a schedule commensurate with their age:

1. Vehicles manufactured within the last five (5) years: no inspection.

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2. Vehicles manufactured within the last six (6) to ten (10) years: inspected every 24 months.

3. Vehicles manufactured eleven (11) years or longer: inspected annually.

4. Vehicles for wheelchair transportation: inspected annually, regardless of the manufacture date of vehicle.

C. The vehicle inspector must be trained to conduct the inspection and be employed by an automotive repair company authorized to do business in Colorado.

.46 Transportation providers who maintain a certificate or permit through the Public Utilities Commission (PUC) are not required to meet the above requirements. PUC certificate and permit holders shall submit a copy of the certification to the Department for verification of provider credentials.

8.494.50 LIMITATIONS AND REIMBURSEMENT

.51 Reimbursement for non-medical transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services.

.52 A provider's submitted charges shall not exceed those normally charged to the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities.

.53 Provider charges shall not accrue when the recipient is not physically present in the vehicle.

.54 Providers shall not bill for services before they are an approved Medicaid provider and may bill only for those NMT services performed by a qualified driver utilizing a qualified vehicle.

.55 Excluding transportation to HCBS Adult Day facilities, a participant may not receive more than the equivalent of two (2) round trip services per week, or 104 round trip services per annual certification period utilizing NMT, unless otherwise authorized by the Department.

.56 A bus pass or other public conveyance may be used only when it is more cost effective than, or comparable to, the applicable service type and duration. Costs cannot exceed the total Wheelchair Van, Mileage Band 1 allowable per service plan. The most current HCBS Rate Schedule can be found on the Department website.

8.495 ALTERNATIVE CARE FACILITIES

8.495.1 DEFINITIONS

Alternative Care Facility (ACF) authorized in 25.5-6-303(3), C.R.S., means an Assisted Living Residence as defined at 6 CCR 1011-1, Chapter VII, Section 2, which has been licensed by the Colorado Department of Public Health and Environment (CDPHE) and has been certified by the Department to provide Alternative Care Services and Protective Oversight to Medicaid participants.

Alternative Care Services as described in 25.5-6-303(4), C.R.S., means, but is not limited to, a package of personal care and homemaker services provided in a state licensed and certified alternative care facility including: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding, ambulation, transfers, positioning, bladder & bowel care, medication reminding and monitoring, accompanying, routine housecleaning, meal preparation, bed making, laundry, and shopping. Alternative Care Services also includes Medication Administration.

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Care Plan means the individualized goal-oriented plan of services, supports, and preferences developed collaboratively with the participant and/or the designated or legal representative and the service provider, as outlined in 6 CCR 1011-1, Chapter VII, Section 2 and , Section 8.495.6.F.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 6 CCR 1011-1, Chapter VII, Section 7.9 and 6 CCR 1011-1, Chapter VII, Section 7.16.

Medication Administration as described in 25-1.5-301, C.R.S., means assisting a participant with taking medications while using standard healthcare precautions, according to the legibly written or printed order of an attending physician or other authorized practitioner. Medication administration may include assistance with ingestion, application, inhalation, and rectal or vaginal insertion of medication, including prescription drugs. Provider must document and keep record of each medication administered, including the time and the amount taken. "Administration" does not include judgment, evaluation, assessment, or the injections of medication, the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by the participant.

Non-Medical Leave Days mean days of leave from the ACF by the participant for non-medical reasons such as family visits.

Programmatic Leave Days mean days of leave from the ACF prescribed for a participant by a physician for therapeutic and/or rehabilitative purposes.

Protective Oversight means care and service as defined at 6 CCR 1011-1, Chapter VII, Section 2 and , Section 8.489.31.S., which includes the monitoring and guidance of a participant to assure their health, safety, and well-being, and a general awareness of a participant's whereabouts. Protective oversight also includes but is not limited to: monitoring the participant while on the premises, monitoring the participant's needs, and ensuring that the participant receives the services and care necessary to protect the participant's health and welfare.

Provider means the entity that holds the Assisted Living Residence/Facility license and certification and shall be responsible or delegate responsibility to appropriate staff for the delivery of Alternative Care Services.

Resident Agreement means a written agreement specifying at a minimum the services to be provided, charges and refund policies, written disclosures of information, discharge procedures, and management of participant funds/property, which shall be signed by the participant and/or participant's guardian or other legal representative as outlined in 6 CCR 1011-1, Chapter VII, Section 11.3-6.

Secured Environment means an ACF that operates as defined in 6 CCR 1011-1, Chapter VII Section 2.

8.495.2 PARTICIPANT ELIGIBILITY

A. Participants in the Home and Community Based Services (HCBS) Elderly, Blind and Disabled waiver pursuant to , Section 8.485 and the HCBS Community Mental Health Supports waiver pursuant to , Section 8.509 are eligible to receive services in an Alternative Care Facility.

B. Potential participants shall be assessed, at a minimum, by a team that includes the participant and/or guardian or other legal representative, the ACF administrator or appointed representative, and Case Management Agency (CMA) case manager. If one of the parties listed above is not available, input or information must be obtained from each party prior to making an admission determination. It may also include family members, Accountable Care Collaborative or Mental Health Center case

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managers, and any other interested parties as approved by the participant, to determine that the ACF is an appropriate community setting that will meet the individual's choice and need for independence and community integration.

1. An assessment will be conducted prior to admission, annually, and whenever there is a significant change in physical, cognitive, or behavioral needs, or as requested by the participant. The annual assessment must be completed by the team outlined in , Sections 8.495.2.B.

2. The assessment will document that the facility is able to support the participant and their needs. The assessment will also document the participant's physical, behavioral and social needs, so that supports can be identified to enable them to lead as independent a life as possible. The assessment will be used to develop the participant's Care Plan.

8.495.3 PARTICIPANT BENEFITS

A. Alternative Care Services which include, but are not limited to, personal care and homemaker services pursuant to , Sections 8.489 and 8.490, are benefits to participants residing in an ACF.

1. Medication Administration is included in the reimbursement rate for Alternative Care Services and shall not be additionally reimbursed or billed in any other manner.

B. Room and board shall not be a benefit of Alternative Care Services. Participants shall be responsible for room and board in an amount not to exceed the Department's established rate.

C. Participant engagement opportunities shall be provided by the ACF, as outlined in 6 CCR 1011-1, Chapter VII, Section 12.19-26.

8.495.4 PARTICIPANT RIGHTS

A. An ACF must be integrated in the community and foster the independence of the participant while promoting each participant's individuality, choice of care, and lifestyle.

1. The participant's choice to live in an ACF shall afford the participant the opportunity to responsibly contribute to the home in meaningful ways and shall avoid reducing personal choice and initiative. The participant's individual behaviors shall not negatively impact the harmony of the ACF.

B. The facility must ensure that a lease, residency agreement, or other form of a written agreement will be in place for each HCBS participant and provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

1. A violation of a lease or resident agreement that leads to a discharge must include at least 30 days' notice to the participant and/or their guardian or other legal representative, and a copy of the written notice shall be sent to the state or local ombudsman within five calendar days of the date that it was provided to the participant.

C. Participants shall be informed of their rights, according to 6 CCR 1011-1, Chapter VII, Section 13. Pursuant to 6 CCR 1011-1, Chapter VII, Section 13.1, the policy on resident rights shall be in a visible location so that they are always available to participants and visitors.

1. These rights include but are not limited to:

a. Participants have the choice in selecting the ACF in which they reside;

b. Participants are afforded the right and opportunity to responsibly contribute to the home in meaningful ways, engage in community life, and express personal choice;

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c. Participants have the right to dignity and privacy, including in their living/sleeping units;

d. Participants shall have choice in a roommate, with the provider accommodating roommate choices. If the facility only has one bed in a two-bed room available, the new individual and the current occupant must at least have a chance to meet and determine whether they are willing to share a room; and

e. Communication with staff that is respectful and in a dignified manner.

2. The following rights may be modified when supported by a specific and assessed need, as determined by the provider, participant, and case manager:

a. Participants have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment;

b. Participants shall have access to food at all times, choose when and what to eat, and shall have access to food preparation areas if they can appropriately handle kitchen equipment as documented in the Care Plan;

c. Participants and their roommates shall have personal quarters with entrance doors lockable by the individual and shall control access to their quarters, unless otherwise specified in their Care Plan. Only appropriate staff shall have keys to private quarter doors, as specified in the Care Plan;

d. Participants shall have the freedom and support to determine their own schedules and activities, including methods of accessing the greater community;

e. Participants shall have the right to possess and self-administer medications with a physician's written order and approval of the self-administration of medications, (along with a copy of the physician's written order supporting self-administration) which shall be documented in the Care Plan;

f. The right to have visitors at any time;

g. The right to control his/her personal resources;

h. The right to have access to the entire facility; and

i. The right to receive unopened mail.

3. The Care Plan must include proper documentation supporting the modification, which includes but is not limited to:

a. Identification of a specific and individualized assessed need;

b. Documentation of the positive interventions and less intrusive methods that have been used to support the well-being and needs of the participant;

c. Informed consent of the participant or their guardian/other legal representative;

d. Documentation of the participant's case manager involvement of any rights modification; and

e. Modifications to the Care Plan and supporting documentation must be reviewed, at a minimum, on an annual basis.

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D. Participants shall be informed of all ACF policies upon admission to the facility, and when changes to policies are made, rules and/or policies shall apply consistently to the administrator, staff, volunteers, and participants residing in the facility and their family or friends who visit. Participant acknowledgement of rules and policies must be documented in the Care Plan or a participant agreement.

E. Participants shall be informed of the facility's policies and procedures for implementation of an individual's advance directives, should the need arise.

F. If requested by the participant, the ACF shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal possessions.

G. Providers shall not require a Medicaid participant to take part in performing household or other related tasks.

8.495.5 PROVIDER ELIGIBILITY

A. The Provider shall be licensed in accordance with 6 CCR 1011-1, Chapters II and VII.

B. Certification Standards

1. The Provider shall be Medicaid certified by the Department as an ACF in accordance with 10 CCR, 2505-10, Section 8.487.20.

2. Certification shall be denied, revoked, terminated or suspended when a Provider is unable to meet, or adequately correct deficiencies relating to, licensure and/or certification standards as defined at 6 CCR 1011-1, Chapter VII and , Section 8.495.

3. ACF Providers shall maintain a copy of any license, ACF certification, proof of insurance or bond, W-9, and any other documentation as required by state or local authority. Providers shall submit to the Department a copy of the assisted living residence license upon renewal or change of ownership.

4. Administrators shall be qualified as defined at 6 CCR 1011-1, Chapter VII, Section 6, prior to Medicaid certification.

C. The Provider shall enter into a Provider Agreement with the Department upon the completion of the provider application and ACF certification.

D. The Provider Agreement shall be denied, revoked, suspended, or terminated if an ACF provider does not operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation, and other standards prescribed in law or regulations.

E. Notification to the Department of Significant ACF Change

1. Suspension, Revocation or Termination

a. ACF Providers shall notify the Department within five working days when any required license, certification, insurance or bond has a change in status, including any suspension, revocation or termination.

2. Change of Ownership

a. Providers shall provide written notice to the Department of intent to change ownership no later than 30 days before the sale of the facility.

i. The new owner shall not automatically become a Medicaid provider without meeting licensing, certification, and approval process standards.

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8.495.6 PROVIDER ROLES AND RESPONSIBILITIES

A. All documentation, including but not limited to, individual resident agreements and Care Plans, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to , Section 8.130 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request.

B. Participant Engagement

1. Providers shall, in consultation with the participants, provide social and recreational engagement opportunities both within and outside the facility.

a. Opportunities for social and recreational engagement shall take into consideration the individual interests and wishes of the participants.

b. In determining the types of opportunities and activities offered, the provider shall consider the physical, social, and mental stimulation needs of the participants.

C. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:

a. Death;

b. Abuse/neglect/exploitation;

c. Injury to participant or illness of participant;

c. Damage or theft of participant's property;

d. Medication mismanagement;

e. lost or missing person;

f. criminal activity;and

g. A harmful act committed against the participant by a person with a relationship to the participant when such act is not defined as abuse, caretaker neglect, or exploitation but causes harm to the health, safety, or welfare of a participant.

2. A provider must submit a written or verbal report of a Critical Incident to the participant's case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

a. Participant name;

b. Participant identification number;

c. Waiver;

d. Incident type;

i. Mistreatment, Abuse, Neglect or Exploitation (MANE)

ii. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury,

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illness, medication management issues, missing persons, unsafe housing or displacement, other high risk issues.

e. Date and time of incident;

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

g. Persons involved;

h. Description of incident; and

i. Resolution, if applicable.

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

3. If any of the above information is not available within 24 hours of incident and not reported to the case manager, a follow-up to the initial report must be completed. Failure to report incidents may result in corrective action by the Department.

D. Participant Leave

1. Providers shall notify the participant's case manager of any participant planned or unplanned non-medical and/or programmatic leave for greater than 24 hours.

2. The therapeutic and/or rehabilitative purpose of leave shall be documented in the participant's Care Plan.

E. Additional Charges

1. Any additional monies assessed to the participant or their family and/or guardian:

a. Shall not be for Medicaid services;

b. Shall be clearly delineated in the resident agreement; and

c. Shall be fully refunded except for withholdings which are in accordance with the resident agreement and are clearly defined on the day of discharge.

F. Care Plan

1. The following information must be documented in the Care Plan:

a. Medical Information:

i. If the participant is taking any medications and how they are administered, with reference to the Medication Administration Record (MAR);

ii. Special dietary needs, if any; and

iii. Reference to any documented physician orders.

b. Social and recreational engagement:

i. The participant's preferences and current relationships; and

ii. Any restrictions on social and/or recreational activities identified by a physician.

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c. Any other special health or behavioral management needs that supports the participant's individual needs.

d. Additional Care Planning Documentation:

i. Documentation from the admission process which demonstrates that the facility was selected by the participant;

ii. Identification of the Individual's goals, choices, preferences, and needs and incorporation of these elements into the supports and services outlined in the Care Plan;

iii. Any modifications to the participants rights, with the required supporting documentation; and

iv. Evidence the participant and/or their guardian, designated representative, or legal representative has had the opportunity to participate in the development of the Care Plan, has reviewed it, and has signed in agreement with the plan.

G. Environmental Standards

1. The Alternative Care Facility is an environment that supports individual comfort, independence and preference, maintains a home-like quality and feel for participants at all times, and provides participants with unrestricted access to the facility in accordance with the residency agreement or modifications as agreed to and documented in the participant's Care Plan.

2. Facilities shall provide an outdoor area accessible to participants without staff assistance that is well maintained, facilitates community gatherings, and is appropriately equipped for the population served.

3. Facilities shall provide access for participants to make private phone calls at their preference and convenience.

4. Facilities shall provide comfortable places for private visits with family, friends and other visitors.

5. Facilities shall provide easily accessible common areas and a physical environment that meets the needs of any participant needing support.

6. Facilities shall maintain a comfortable temperature throughout the facility and participant rooms, sufficient to accommodate the use and needs of the participants, never to exceed 80 degrees.

7. The facility shall develop and follow written policies and procedures to ensure the continuation of necessary care to all residents for at least 72 hours immediately following any emergency including, but not limited to, a long-term power failure.

8. The monthly schedule of daily recreational and social engagement opportunities shall be in a visible location so that they are always available to participants and visitors, and developed in accordance with 6 CCR 1011-1, Chapter VII, Section 12.26, pertaining to Resident Engagement.

a. Staff shall be responsible for ensuring that the daily schedule of recreational and social engagement opportunities is implemented and offered to all participants.

9. Reading material shall be available in the common areas at all times, reflecting the interests, hobbies, and requests of the participants.

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10. Facilities shall provide nutritious food and beverages that participants have access to at all times. Access to food and cooking of food shall be in accordance with 6 CCR 1011-1, Chapter VII, Section 17.1-3. The access to food shall be provided in at least one of the following ways:

    a. Access to the ACF kitchen.

    b. Access to an area separate from the ACF kitchen stocked with nutritious food and beverages.

    c. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the participant's bedroom.

    d. A safe, sanitary way to store food in the participant's room.

11. Each participant's cooking capacity shall be assessed as part of the pre-admission process and updated in the Care Plan as necessary.

H. Provider Service Requirements

1. The facility shall provide Protective Oversight and Alternative Care services to participants every day of the year, 24 hours per day.

2. Alternative Care Facility Providers shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 CCR 1011-1, Chapter VII and XXIV, Medication Administration Regulations.

3. Providers shall not discontinue services to a participant unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services.

4. The facility shall develop emergency policies that address, at a minimum, a plan that ensures the availability of, or access to, emergency power for essential functions and all resident-required medical devices or auxiliary aids.

5. Providers shall have written policies and procedures for employment practices.

6. Providers shall maintain the following records/files:

    a. Personnel files for all staff and volunteers shall include:

        i. Name, home address, phone number and date of hire.

        ii. The job description, chain of supervision and performance evaluation(s).

    b. It shall be the responsibility of the Administrator to establish written policies concerning employee health, as outlined in 6 CCR 1011-1, Chapter VII, Section 7.6.

    c. Participant files shall be kept confidential and shall include:

        i. The participant's assessment outlined in , Sections 8.495.2. B. and Care Plan per 8.495.6.F.

7. The facility shall encourage and assist participants' participation in engagement opportunities and activities within the ACF community and the wider community, when appropriate.

I. Staffing Requirements

1. Each facility will divide the 24-hour day into two 12-hour blocks which will be considered daytime and nighttime. The designation of daytime and nighttime hours shall be permanently

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documented in facility policy and disclosed in the written resident agreements. In determining appropriate staffing levels, the facility shall adjust staffing ratios based on the individual acuity and needs of the participants in the facility. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition Direct Care Staff defined at , Sections 8.495.1. Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

2. Staffing at a facility shall be no less than the following standards:

a. A minimum of 1 staff to 10 participants during the daytime.

b. A minimum of 1 staff to 16 participants during the nighttime.

c. A minimum of 1 staff to 6 participants in a Secured Environment at all times.

i. There shall be a minimum of one awake staff member that is on duty during all hours of operation in a Secured Environment.

3. Staffing Ratio Waiver

a. Staffing waiver requests shall be submitted to the Department's ACF Benefit Administrator. They will be evaluated and granted based on several criteria. This includes, but is not limited to:

i. Years facility has been in operation;

ii. Past Critical Incidents at the facility;

iii. The Provider has adequately documented how a staffing waiver would not jeopardize the health, safety or quality of life of the participants;

iv. Provider availability and memberclient access; and

v. Free of deficiencies impacting participant health and safety in both the CDPHE and Life Safety Code survey and inspections.

b. An approved staffing waiver is only applicable for nighttime hours, with the exception for Secured Environments.

c. A staffing waiver expires five years from the date of approval. Continuance of staffing waiver requires Department approval.

d. Any existing staffing waiver may be subject to revocation if a facility does not comply with any applicable regulations, is cited with deficiencies impacting participant health and safety by CDPHE or the Division of Fire Protection Control, has substantiated patient care complaints, or the staffing waiver has jeopardized the health, safety or quality of life of the participants.

i. In the event of a staffing waiver denial or revocation, a facility may reapply for a staffing waiver only after the facility receives a CDPHE and Life Safety survey with no deficiencies impacting participant health and safety

ii. Existing staffing waivers shall be null and void upon a change in the total number of licensed beds or a change of ownership in a facility.

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4. The facility shall ensure that all staff and volunteer training be completed within the first 30 days of employment. Training shall include, but is not limited to, the training topics outlined in 6 CCR 1011-1, Chapter VII, Section 7.9.

5. The Provider shall ensure the Administrator and all staff meet the qualifications and employment standards set forth in 6 CCR 1011-1, Chapter VII, Section 7.4-7.

J. Standards for Secured Environment ACFs

1. Facilities providing a secured environment may be licensed for a maximum of 30 secured beds.

a. A waiver may be granted by the Department when adequate documentation of the need for additional beds has been proven and the number of beds would not jeopardize the health, safety and quality of care of participants.

2. The facilities shall establish an environment that promotes independence and minimizes agitation and unsafe wandering through the use of visual cues and signs.

3. Provide a secured outdoor area accessible without staff assistance, which shall be level, well maintained, and appropriately equipped for the population served.

K. Appropriateness of Medicaid Participant Placement

1. An ACF shall not admit, or shall discharge within 30 days, any participant, who:

a. Needs skilled services on more than an intermittent basis. Skilled services shall only be provided on an intermittent basis by a Medicaid certified home health provider.

b. Is diagnosed with a substance abuse issue and refuses treatment by the appropriate mental health and/or medical professionals and cannot be safely served by the facility.

c. Has an acute physical illness which cannot be managed through medications or prescribed therapy.

e. Exhibits behavior that:

i. Disrupts the safety, health and social needs of the home.

ii. Poses a physical threat to self or others, including but not limited to, violent and disruptive behavior and/or any behavior which involves physical, sexual, or psychological force or intimidation and fails to respond to interventions, as outlined in the participant's Care Plan.

iii. Demonstrates an unwillingness or inability to maintain appropriate personal hygiene under supervision or with assistance.

iv. Is consistently disorientated to time, person and place to such a degree they pose a danger to self or others and the ACF does not provide a Secured Environment.

h. Has physical limitations that:

i. Limit ambulation, unless compensated for by assistive device(s) or with assistance from staff.

2. All discharges, including emergency discharges, shall be in accordance to 6 CCR 1011-1, Chapter VII, Section 11.11.

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3. Participants admitted for Respite Care to the ACF must meet the same criteria as other participants for appropriate placement.

8.495.7 REIMBURSEMENT

A. Effective January 1 of each year, the Department shall establish a uniform room and board payment for all Medicaid participants in ACFs. The standard room and board payment shall be permitted to rise in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises its grant amounts.

1. Providers shall not charge a Medicaid participant more than the Department's annually established room and board rate. The room and board rate shall include but is not limited to: basic furniture, linens, utilities, and basic toiletries to include: toilet paper, soap, tissues, shampoo, toothpaste, and toothbrush.

B. ACFs must bill for reimbursement in accordance with the Department rules, policies and procedures.

1. Reimbursement shall be per unit, with one unit equaling one day of care, as outlined on the Prior Authorization (PAR) form.

2. When a participant is determined eligible for HCBS services under the 300% income standard pursuant to 10 CCR 2505-10, Section 8.100, Medicaid reimbursement shall be determined for Alternative Care Services according to 10 CCR 2505-10, Section 8.486.60.

C. Reimbursement shall be the lower of:

1. The Medicaid unit rate; or

2. The rate the ACF charges its private-pay residents for similar services.

D. Non-Medical/Programmatic Leave Reimbursement

1. The ACF may receive reimbursement for a maximum of 42 days in a calendar year for Non-Medical/Programmatic Leave Days combined.

2. The ACF cannot bill for services during Leave Days if participant is receiving Medicaid services over 24 hours in another approved Medicaid Facility, such as a nursing facility or hospital.

8.500 HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES(HCBS-DD) WAIVER

8.500.1 This Section hereby incorporates the terms and provisions of the federally approved Home and Community-based Services for Individuals with Intellectual or Developmental Disabilities (HCBS-DD) waiver. To the extent that the terms of that federally approved waiver are inconsistent with the provisions of this Section, the waiver will control.

8.500.1 DEFINITIONS

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A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD waiver or a HCBS waiver service.

C. APPLICANT means as defined in Section 8.390.1.

D. AUDITABLE means the information represented on the wavier cost report can be verified by reference to adequate documentation as required by generally accepted auditing standards.

E. AUTHORIZED REPRESENTATIVE means an individual designated by a MemberClient, or by the parent or guardian of the MemberClient receiving services, if appropriate, to assist the MemberClient receiving services in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.

F. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

G. MEMBERCLIENT means an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

H. MEMBERCLIENT REPRESENTATIVE means a person who is designated by the MemberClient to act on the MemberClient's behalf. A MemberClient Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the MemberClient to speak for or act on the MemberClient's behalf.

I. COMMUNITY CENTERED BOARD means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State-Funded programs for individuals with intellectual and developmental disabilities.

J. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing home and community-based services and Medicaid state plan benefits including long-term home health services and targeted case management.

K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the MemberClient.

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

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means as defined in 8.280.1.

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P. FAMILY means a relationship as it pertains to the MemberClient and is defined as:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a Member Client with an intellectual or developmental disability has been given by a court; or,

A spouse; or,

The MemberClient's children.

Q. GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) MemberClients receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment as a residential care facility or residential community home for persons with developmental disabilities.

R. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem S, as set forth in Section 15-14-102 (4), C.R.S.

S. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

T. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a MemberClient who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IIDD)

U. INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation services provided to three (3) or fewer MembersClients in a single residential setting or in a host home setting that does not require licensure by the Colorado Department of Public Health and Environment.

V. INSTITUTION means a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IIDD) for which the Department makes Medicaid payment under the Medicaid State Plan.

W. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately-operated facility that provides health and habilitation services to a Member Client with an intellectual or developmental disability or related conditions.

X LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the MemberClient's spouse.

Y. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a MemberClient must require in order to receive services in an institutional setting under the Medicaid State Plan.

Z. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

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AA. MEDICAID ELIGIBILE means an Applicant or MemberClient meets the criteria for Medicaid benefits based on the Applicant's financial determination and disability determination when applicable.

BB. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

CC. MEDICATION ADMINISTRATION means assisting a MemberClient in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

DD. NATURAL SUPPORTS means non-paid informal relationships that provide assistance and occur in the MemberClient's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

EE. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

FF. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

GG. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent or the Case Management Agency.

HH. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

II PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined Section 8.600.4 et seq., that has received program approval to provide HCBS-DD waiver services.

JJ. PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use, including vehicles for hire.

KK. RELATIVE means a person related to the MemberClient by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor's review after services and supports are provided to ensure the MemberClient received services according to the support plan and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

MM. STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER means the state owned and operated agency providing HCBS waiver services to MemberClients enrolled in the HCBS-DD waiver.

NN. SUPPORT is any task performed for the MemberClient where learning is secondary or incidental to the task itself or an adaptation is provided.

OO. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the MemberClient well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

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PP. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; assessment and periodic Reassessment, development and periodic revision of a PCSP,, referral and related activities, and monitoring.

QQ. THIRD PARTY RESOURCES means services and supports that a MemberClient may receive from a variety of programs and funding sources beyond natural supports or Medicaid. That may include, but are not limited to, community resources, services provided through private insurance, non-profit services and other government programs.

RR. WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.500.2 HCBS-DD WAIVER ADMINISTRATION

8.500.2.A HCBS-DD shall be provided in accordance with the federally approved waiver document and these rules and regulations.

8.500.2.B The HCBS-DD waiver provides the necessary support to meet the daily living needs of a MemberClient who requires access to 24-hour support in a community-based residential setting.

8.500.2.C HCBS-DD Waiver services are available only to address those needs identified in the LOC Screen and authorized in the PCSP and when the service or support is not available through the Medicaid state plan, EPSDT, natural supports or third-party resources.

8.500.2.D THE HCBS-DD WAIVER:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments do not to exceed the federally approved capacity, and

4. May limit the enrollment when utilization of the HCBS-DD Waiver program is projected to exceed the spending authority.

8.500.3 GENERAL PROVISIONS

8.500.3.A The following provisions shall apply to the HCBS-DD waiver.

1. HCBS-DD waiver services shall be provided as an alternative to ICF-IID services for a MemberClient with intellectual or developmental disabilities.

2. HCBS-DD is waived from the requirements of Section 1902(a)(10)(B) of the Social Security Act concerning comparability of services. The availability of some services may not be consistent throughout the State of Colorado.0

3. A MemberClient enrolled in the HCBS-DD waiver shall be eligible for all other Medicaid services for which the MemberClient qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-DD waiver. Services received through the HCBS-DD waiver may not duplicate services available through the state plan.

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8.500.4 MEMBERCLIENT ELIGIBILITY

8.500.4.A To be eligible for the HCBS-DD waiver, an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability,
2. Be eighteen (18) years of age or older,
3. Require access to services and supports twenty-four (24) hours a day,
4. Meet ICF-IID level of care as determined by the LOC Screen, and
5. Meet the Medicaid financial determination for LTC eligibility as specified in Section 8.100, *et seq.*

8.500.4.B The MemberClient shall maintain eligibility by meeting the criteria as set forth in Section 8.500.6.A.1 and .2 and the following:

1. Receives at least one (1) HCBS waiver service each calendar month.
2. Is not simultaneously enrolled in any other HCBS waiver.
3. Is not residing in a hospital, nursing facility, ICF-IID, correctional facility or other institution.
4. Is served safely in the community with the type and amount of waiver services available and within the federally approved capacity and cost containment limits of the waiver.
5. Resides in a GRSS or IRSS setting.

8.500.4.C When the HCBS-DD Waiver reaches capacity for enrollment, a MemberClient determined eligible for the waiver shall be eligible for placement on a wait list in accordance with these rules at Section 8.500.7.

8.500.5 HCBS-DD WAIVER SERVICES

8.500.5.A SERVICES PROVIDED

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

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11. Transition Setup

12. Vision Services

13. Workplace Assistance

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 MemberClient's developmental disability which assist a MemberClient to acquire or maintain appropriate interactions with others.

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

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

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

   d. Behavioral Services include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Benefits Planning is the analysis and guidance provided to a member and their family/support network to improve their understanding of the potential impact of employment-related income on the member's public benefits. Public benefits include, but are not limited to: Social Security, Medicaid, Medicare, food/nutrition programs, housing assistance, and other federal, state, and local benefits. Benefits Planning gives the member an opportunity to make an informed choice regarding employment opportunities or career advancement.

a. Benefits Planning may only be provided by Certified Benefits Planners. A Certified Benefits Planner holds at least one of the following credentials:

i. Community Work Incentives Coordinator (CWIC);

ii. Community Partner Work Incentives Counselor (CPWIC);

iii. Credentialed Work Incentives Practitioner (WIP-CTM).

b. Documentation of the Benefits Planner's certification and additional trainings shall be maintained and provided upon request by a surveyor or the Department.

c. Certified Benefits Planners must obtain and sustain a working knowledge of Colorado's Medicaid Waiver system as well as federal, state, and local benefits.

d. If the Certified Benefits Planner encounters a benefit situation that is beyond their expertise, consultation with technical assistance liaisons is expected.

e. Benefits Planning is available regardless of employment history or lack thereof, and can be accessed throughout the phases of a member's career such as: when considering employment, changing jobs, or for career advancement/exploration. Certified Benefits Planners support members by providing any of these core activities:

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i. Intensive individualized benefits counseling;

ii. Benefits verification;

iii. Benefit summary & analysis (BS&A);

iv. Identifying applicable work incentives, and if needed, developing a work incentive plan for the member and team;

v. In addition to the core activities, Benefits Planning may also be utilized to:

1) Conduct an informational meeting with the member, alone or with their support network.

2) Assist with evaluating job offers, promotional opportunities (increase in hours/wage), or other job changes that the member is considering which changes income levels; and outlining the impact that change may have on public benefits.

3) Provide information on Waiver benefits (including Buy-In options), federal/state/local programs, and other resources that may support the member in maintaining benefits while pursuing employment.

4) Assist with referrals and connecting the member with identified resources, as needed; as well as coordinating with member, Case Manager, family, and other team members to promote accessing services/resources that will advance the member's desired employment goals.

5) Navigate complicated benefit scenarios and offer problem-solving strategies, so that the member may begin or continue working while maintaining eligibility for needed services.

6) Offer suggestions to the member and their family/support network regarding how to create and maintain a recordkeeping structure and reporting strategy related to benefit eligibility and requirements.

a) If the member needs assistance with the collection and submission of income statements and/or documentation related to the Social Security Administration (SSA), or other benefits managing organizations, and the member does not have other supports to do so, the Benefits Planner may assist on a temporary basis.

i. The Benefits Planning provider must maintain records which reflect the Benefits Planning activities that were completed for the member, including copies of any reports provided to the member.

f. In collaboration with the member's Case Manager and support team, a Benefits Planner can assist in accessing federal/state/local resources, evaluate the potential impact on benefits due to changes in income, and if there is a negative impact identified the Benefits Planner can help brainstorm alternatives to meet existing needs.

g. Benefits Planning shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.

h. Benefits Planning services are limited to forty (40) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

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

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

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

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

i) Include the opportunity for Member Clients to select from Age Appropriate Activities and Materials, as defined in Section 8.484.2.A., both within and outside of the setting.

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

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

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

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

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

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

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

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

e. Prevocational Services are provided to prepare a MemberClient for paid community employment. Services consist of teaching concepts including attendance, task

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completion, problem solving and safety, and are associated with performing compensated work.

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

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

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

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

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

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

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

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

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

a. Preventative services include:

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

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv). Non-intravenous sedation,

v) Basic and deep cleanings,

vi). Mouth guards,

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vii) Topical fluoride treatment, and

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

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

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

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth

c. Major services include:

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

ii) Crowns

iii) Bridges

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

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

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

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

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

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

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

5. Home Delivered Meals as defined at Section 8.553.1.

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

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

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

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

7. Peer Mentorship as defined at Section 8.553.1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Specialized Medical Equipment and Supplies include:

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

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

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

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

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

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

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

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

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

b. Supported Employment may be delivered in a variety of settings in which MemberClients have the opportunity to interact regularly with individuals without disabilities, other than those individuals who are providing services to the MemberClient.

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

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

e. Group Employment including mobile crews shall not exceed eight (8) MembersClients.

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

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

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

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

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

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

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

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

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

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

m. If a member is employed, the supervision the member needs while at work shall be clearly documented in their Person-Centered Support Plan (PCSP). A member's supervision level at work must be based on the member's specific work-related support needs.

i. The level of supervision by paid caregivers may be lower at work than in other community settings, and the member should not be over-supported or limited in their availability to work based on supervision needs identified for other settings.

11. Transition Setup services as defined at Section 8.553.1.

12. 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 MemberClient who is at least twenty-one (21) years of age.

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

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

ii) Prior authorized in accordance with Operating Agency procedures.

13. Workplace Assistance services provide work-related supports for members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver that is above and beyond what could be regularly supported by the workplace supervisor, co-workers, or job coach, in order to maintain an individual job in an integrated work setting for which the member is compensated at or above minimum wage. Training/Job Coaching, accommodations, technology, and natural supports are to be used to maximize the member's independence and minimize the need for the consistent presence of a paid caregiver. As such, the degree to which the member must be supported by a paid caregiver through the Workplace Assistance service, shall be based on the specific safety-related need(s) identified in the person-centered planning process for the member at their worksite.

a. Workplace Assistance:

i. is provided on an individual basis, not within a group and cannot overlap with job coaching;

ii. occurs at the member's place of employment, during the member's work hours, and when needed may also be used:

1) immediately before or after the member's employment hours,

2) during work-related events at other locations;

iii. includes but is not limited to: promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs, redirecting, reminding to follow work-related protocols/ strategies, and ensuring other identified needs are met so the member can be integrated and successful at work;

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iv. may include activities beyond job-related tasks that support integration at work, such as assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events.

b. Workplace Assistance is appropriate for and available to:

i. Members who require Intensive Supervision or have a documented need which warrants a Rights Modification requiring extensive supervision, such as, a court order or the member meeting Public Safety Risk or Extreme Risk-to-Self criteria pursuant to Section 8.612.5(i) definitions. Members whose support team agrees there is justification for a paid caregiver to be present for a portion of the hours worked due to safety concerns; and those needs are beyond what could be addressed through natural supports, technology, or intermittent Job Coaching.

1) The specific safety concerns identified by members and their support teams may include, but are not limited to:

a) regularly demonstrating behaviors that cause direct harm to themselves or others;

b) intentionally or unintentionally putting themselves in unsafe situations frequently;

c) often demonstrating poor safety awareness or making poor decisions related to personal safety.

2) A member's supervision level is not the sole factor which justifies the need for this service, therefore, the supervision level shall not be elevated in order to access the service. The member's supervision level at the worksite shall be based on actual need related to the member at work.

c. Prior to Workplace Assistance being authorized, including at the Person-Centered Support Plan's annual renewal, the member and their support team shall determine that alternatives to paid caregiver supports were fully explored, by considering the factors listed below. Documentation of these considerations shall be reflected in the member's Case Management record.

i. Job Coaching services have been or will be leveraged to promote the member's independence and minimize the need for the presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, promoting natural supports, integrating technology, and using systematic instruction techniques.

ii. The specific safety concern(s) to be addressed and how the Workplace Assistance staff could support the member in addressing the safety concerns while facilitating integration and independence at work.

iii. The nature of the job and work location, the member's longevity with the employer, the degree of continuity at the member's place of employment, and the likelihood of the member putting themselves/others in harm's way, despite training, technology, and cues from natural supports.

iv. The member's desire to have a paid caregiver present for the identified time periods.

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v. The Supported Employment provider's informed opinion regarding the need for paid caregiver support beyond intermittent Job Coaching. This opinion should be grounded in Employment First concepts as evidenced by:

1) The provider's completion of a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification); or

2) If the Supported Employment provider does not possess this credentialing, then the Supported Employment provider or the Case Manager may consult with:

a) by someone who does possess either a Training Certificate or Certification

b) or a representative from the Department of Health Care Policy and Financing who oversees the Workplace Assistance benefit.

d. Workplace Assistance staff shall consistently seek to promote the member's independence and integration at work.

i) Where possible, efforts should be made to reduce or eliminate the need for Workplace Assistance services over time, and the efforts and progress shall be documented by the provider.

ii) The training for Workplace Assistance staff should:

1) include fundamentals of Employment First principles with emphasis on promoting independence and inclusion;

2) provide insight regarding a paid caregiver's role at a member's place of employment such that the Workplace Assistance staff's presence does not hinder the member's interaction with co-workers, customers, and other community members.

8.500.6 SERVICE PLAN

8.500.6.A The Case Management Agency shall complete a Service Plan for each MemberClient enrolled in the HCBS-DD waiver in accordance with Section 8.519.11.B.2.

8.500.6.D The Service Plan must be reported in the Department prescribed system and include the following employment information for individuals eligible for or receiving Supported Employment services, if applicable:

1. Sector and type of employment;

2. Mean wage per hour earned; and

3. Mean hours worked per week.

8.500.7 WAITING LIST PROTOCOL

8.500.7.A There shall be one waiting list for persons eligible for the HCBS-DD waiver when the total capacity for enrollment or the total appropriation by the general assembly has been met.

8.500.7.B The name of a person eligible for the HCBS-DD waiver program shall be placed on the waiting list by the community centered board making the eligibility determination.

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8.500.7.C When an eligible person is placed on the waiting list for HCBS-DD waiver services, a written notice of action including information regarding MemberClient rights and appeals shall be sent to the person or the person's legal guardian in accordance with the provisions of Section 8.057 *et seq*.

8.500.7.D The placement date used to establish a person's order on a waiting list shall be:

1. The date on which the person was initially determined to have a developmental disability by the community centered board; or

2. The fourteenth (14) birth date if a child is determined to have a developmental disability by the community centered board prior to the age of fourteen.

8.500.7.E As openings become available in the HCBS-DD Waiver program in a designated service area, that community centered board shall report that opening to the Operating Agency.

8.500.7.F Persons whose name is on the waiting list shall be considered for enrollment to the HCBS-DD waiver in order of placement date on the waiting list. Exceptions to this requirement shall be limited to:

1. An emergency situation where the health and safety of the person or others is endangered, and the emergency cannot be resolved in another way. Persons at risk of experiencing an emergency are defined by the following criteria:

   a. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; or whose primary residence during the night is a public or private facility that provides temporary living accommodations; or any other unstable or non-permanent situation; or is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

   b. Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in the person's present living situation and the person's health, safety or well-being is in serious jeopardy.

   c. Danger to others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure safety of the person in the community.

   d. Danger to self: a person's medical, psychiatric or behavioral challenges are such that the person is seriously injuring/harming self or is in imminent danger of doing so.

   e. Loss or Incapacitation of Primary Caregiver: a person's primary caregiver is no longer in the person's primary residence to provide care; or the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or the primary caregiver is age 65 years or older and continuing to provide care poses an imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.

8.500.7.G Enrollments may be reserved to meet statewide priorities that may include:

1. A person who is eligible for the HCBS-DD Waiver and is no longer eligible for services in the foster care system due to an age that exceeds the foster care system limits,

2. Persons who reside in long-term care institutional settings who are eligible for the HCBS-DD Waiver and have a requested to be placed in a community setting, and

3. Persons who are in an emergency situation.

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8.500.7.H Enrollments shall be authorized to persons based on the criteria set forth by the general assembly in appropriations when applicable.

8. 500.7.I. A person shall accept or decline the offer of enrollment within thirty (30) calendar days from the date the enrollment was offered. Reasonable effort shall be made to contact the person, family, legal guardian, or other interested party.

1. Upon a written request of the person, family, legal guardian, or other interested party an additional thirty (30) calendar days may be granted to accept or decline an enrollment offer.

2. If a person does not respond to the offer of enrollment within the allotted time, the offer is considered declined and the person will maintain their order of placement date.

8.500.8 MEMBERCLIENT RESPONSIBILITIES

8.500.8.A A MemberClient or guardian is responsible to:

1. Provide accurate information regarding the MemberClient's ability to complete activities of daily living,

2. Assist in promoting the MemberClient's independence,

3. Cooperate in the determination of financial eligibility for Medicaid,

4. Notify the case manager within thirty (30) days after:

a. Changes in the MemberClient's support system, medical, physical or psychological condition or living situation including any hospitalizations, emergency room admissions, placement to a nursing home or ICF-IID,

b. The MemberClient has not received an HCBS waiver service during one (1) month,

c. Changes in the MemberClient's care needs,

d. Problems with receiving HCBS waiver services,

e. Changes that may affect Medicaid financial eligibility including prompt reporting of changes in income or assets.

8.500.9 PROVIDER REQUIREMENTS

8.500.9.A A private or profit or not for profit agency or government agency shall meet the minimum provider qualifications as set forth in the HCBS waiver and shall:

1. Conform to all state established standards for the specific services they provide under HCBS-DD,

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in Section 8.130,

4. Discontinue services to a MemberClient only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services,

5. Have written policies governing access to duplication and dissemination of information from the MemberClient's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S., as amended,

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6. When applicable, maintain the required licenses from the Colorado Department of Public Health and Environment, and

7. Maintain MemberClient records to substantiate claims for reimbursement according to Medicaid standards.

8. HCBS-DD providers shall comply with:

a. All applicable provisions of Title 27 Article10.5, C.R.S., and all rules and regulations as set forth in 2 CCR 503-1, Section 16.

b. All federal program reviews and financial audits of the HCBS-DD waiver services,

c. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,

d. Requests from the County Departments of Social/Human Services to access records of MemberClients receiving services held by Case Management Agencies as required to determine and re-determine Medicaid eligibility

e. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-DD waiver, and

f. Requests by the Case Management Agency to monitor service delivery through targeted case management activities..

8.500.9.B Supported Employment provider training and certification requirements

1. Supported Employment service providers, including Supported Employment professionals who provide individual competitive integrated employment, as defined in 34 C.F.R. 361.5(c)(9) (2018), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and certification requirements. The incorporation of 34 C.F.R. 361.5(c)(9) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of the incorporated material will be provided at cost upon request.

a. Subject to the availability of appropriations for reimbursement in section 8.500.14.H. Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

i. Deadlines.

1) Existing staff, employed by the Provider on or before July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

2) Newly hired staff, employed by the Provider after July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

a) Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

ii. Department approval required.

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1) The Training Certificate or Certification required under section 8.500.9.B.1.a must be pre-approved by the Department.

a) Providers must submit the following information to the Department for pre-approval review:

i) Provider name.

ii) A current Internal Revenue Service Form W-9.

iii) Seeking approval for:

1) Training Certificate, or

2) Certification, or

3) Training Certificate and Certification.

iv) Name of training, if applicable, including:

1) Number of staff to be trained.

2) Documentation that the training is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

v) Name of Certification, if applicable, including:

1) Number of staff to receive Certification.

2) Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

vi) Dates of training, if applicable, including:

1) Whether a certificate of completion is received.

vii) Date of Certification exam, if applicable.

b) Department approval will be based on alignment with the following core competencies:

i) Core values and principles of Supported Employment, including the following:

1) The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.

ii) The Person-centered process, including the following:

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1) The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-centered approach includes working with a team where the individual chooses the people involved on the team and receives: necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.

iii) Individualized career assessment and planning, including the following:

1) The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.

iv) Individualized job development, including the following:

1) Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.

v) Individualized job coaching, including the following:

1) Providing necessary workplace supports to MemberClients with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.

vi) Job Development, including the following:

1) Effectively engaging employers for the purpose of community job development for MemberClients with significant disabilities, which meets the needs of both the employer and the MemberClient.

c) The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and notify the Provider of its determination within 30 days of receiving the pre-approval request under 8.500.9.B.1.a.ii.1.a.

8.500.10 TERMINATION OR DENIAL OF HCBS-DD MEDICAID PROVIDER AGREEMENTS

8.500.10.A The Department may deny or terminate an HCBS-DD Medicaid Provider Agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq.*

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2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-DD services.

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior memberclient notification.

5. The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with the procedures at 10 CCR 2505-10, Section 8.050.

8.500.11 ORGANIZED HEALTH CARE DELIVERY SYSTEM

8.500.11.A The Organized Health Care Delivery System (OHCDS) for the HCBS-DD Waiver is the Community Centered Board as designated by the Operating Agency in accordance with § 27-10.5-103 C.R.S..

8.500.11.B The OHCDS is the Medicaid provider of record for a memberclient whose services are delivered through the OHCDS.

8.500.11.C The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS according to the current federally approved waiver.

8.500.11.D The OHCDS may contract or employ for delivery of HCBS waiver services.

8.500.11.E The OCHDS shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS waiver,

2. Ensure that services are delivered according to the waiver definitions and as identified in the memberclient's service plan,

3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

4. Monitor the health and safety for HCBS memberclients receiving services from a subcontractor.

8.500.11.F The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

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2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to memberclients,

4. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and Operating Agency procedures,

a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

5. Collect and maintain the data used to develop provider rates and ensure that the data includes costs for services to address the memberclient's needs, that are allowable activities within the HCBS service definition and that supports the established rate,

6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency or Centers for Medicare and Medicaid Services (CMS), and

7. Report by August 31st of each year, the names, rates and total payments made to the contractor.

8.500.12 PRIOR AUTHORIZATION REQUESTS

8.500.12.A Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14.

8.500.13 RETROSPECTIVE REVIEW PROCESS

8.500.13.A Services provided to a MemberClient are subject to a Retrospective Review by the Department and the Operating Agency. This Retrospective Review shall ensure that services:

1. Identified in the service plan are based on the MemberClient's identified needs as stated in the functional needs assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a MemberClient are in accordance with the service plan, and

4. Provided within the specified HCBS service definition in the federally approved HCBS-DD waiver,

8.500.13.B When the retrospective review identifies areas of noncompliance, the Case Management Agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.13.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.500.13.D When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.14 PROVIDER REIMBURSEMENT

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8.500.14.A Providers shall submit claims directly to the Department's Fiscal Agent through the Medicaid Management Information System (MMIS); or through a qualified billing agent enrolled with the Department's Fiscal Agent.

8.500.14.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally-approved HCBS-DD waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the MemberClient's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.14.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.14.D When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.14.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.14.F For private providers payment is based on a statewide fee schedule.

8.500.14.G Reimbursement paid to State or local government HCBS waiver providers differs from the amount paid to private providers of the same service. No public provider may receive payments in the aggregate that exceed its actual costs of providing HCBS waiver services.

1. Reimbursement paid to State and local government HCBS waiver providers shall not exceed actual costs. All State and local HCBS waiver providers must submit an annual cost report for HCBS waiver services.

2. Actual costs will be determined on the basis of the information on the HCBS waiver cost report and obtained by the Department or its designee for the purposes of cost auditing.

a. The costs submitted by the provider for the most recent available final cost report for a 12-month period shall be used to determine the interim rates for the ensuing 12 month period effective July 1 of each year.

i. The interim rate will be calculated as total reported costs divided by total units per HCBS waiver service.

ii. An interim rate shall be determined for each HCBS waiver service provided.

iii. The most recent available final cost report will be used to set the next fiscal year's interim rates.

b. Reimbursement to State and local government HCBS waiver providers shall be adjusted retroactively after the close of each 12-month period.

c. Total costs submitted by the provider shall be reviewed by the Department or its designee and result in a total allowable cost.

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d. The Department will determine the total interim payment through the MMIS.

e. The Department will reconcile interim payments to the total allowable and make adjustments to payments as necessary. Interim payments shall be paid through the MMIS.

3. Submission of the HCBS waiver cost report shall occur annually for costs incurred during the prior fiscal year.

a. The cost report for HCBS waiver services must be submitted to the Department annually on October 31 to reflect costs from July 1-June 30.

b. The cost report will determine the final adjustment to payment for the period for which the costs were reported.

c. Reconciliation to align the fiscal year reimbursement with actual fiscal year costs after the close of each fiscal year shall be determined by the Department annually.

e. A State or local government HCBS waiver provider may request an extension of time to submit the cost report. The request for extension shall:

i. Be in writing and shall be submitted to the Department.

ii. Document the reason for failure to comply.

iii. Be submitted no later than ten (10) working days prior to the due date for submission of the cost report.

f. Failure of a State or local government HCBS waiver provider to submit the HCBS waiver cost report by October 31 shall result in the Department withholding all warrants not yet released to the provider as described below:

i. When a State or local government HCBS waiver provider fails to submit a complete and auditable HCBS waiver cost report on time, the HCBS waiver cost report shall be returned to the facility with written notification that it is unacceptable.

1. The State or local government HCBS waiver provider shall have either 30 days from the date of the notice or until the end of the cost report submission period, whichever is later, to submit a corrected HCBS waiver cost report.

2. If the corrected HCBS waiver cost report is still determined to be incomplete or un-auditable, the State or local government HCBS waiver provider shall be given written notification that it shall, at its own expense submit a HCBS waiver cost report prepared by a Certified Public Accountant (CPA). The CPA shall certify that the report is in compliance with all Department rules and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

3. The Department may withhold all warrants not yet released to the provider when the original cost report submission period and 30-day extension have expired and an auditable HCBS waiver cost report has not been submitted.

ii. If the audit of the HCBS waiver cost report is delayed by the state or local government HCBS waiver provider's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the

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audit is completed. Lack of cooperation shall mean failure to provide documents, personnel or other resources within its control and necessary for the completion of the audit.

4. Non-allowable costs for State and local government providers offering HCBS waiver services include:

a. Room and Board;

b. Costs which have been allocated to an ICF-/IID;

c. Costs for which there is either no supporting documentation or for which the supporting documentation is not sufficient to validate the costs;

d. Costs for services that are available through the Medicaid State Plan or provided on an HCBS waiver other than the HCBS-DD waiver ;

e. Costs for services that are not authorized on an approved HCBS-DD waiver PAR.

f. Costs for services that are not authorized by the Department as an HCBS waiver service;

g. Costs which are not reasonable, necessary, and MemberClient related.

5. Adjustment(s) to the HCBS waiver cost report shall be made by the Department's contract auditor to remove reported costs that are non-allowable.

a. Following the completion of an audit of the cost report the Department or its contract auditor shall notify the affected State or local government HCBS waiver provider of any proposed adjustment(s) to the costs reported on the HCBS waiver cost report and include the basis of the proposed adjustment(s).

b. The provider may submit additional documentation in response to a proposed adjustment. The Department or its contract auditor must receive the additional documentation or other supporting information from the provider within 14 calendar days of the date of the proposed adjustments letter or the documentation will not be considered.

c. The Department may grant a reasonable period, no longer than 30 calendar days, for the provider to submit such documents and information, when necessary and appropriate, given the providers' particular circumstances.

d. The Department or its contract auditor shall complete the audit of the cost report within 30 days of the submission of documentation by the provider.

8.500.14.H Reimbursement for a Supported Employment Training Certificate or Certification, or both, under section 8.500.9.B.1.a, which includes both the cost of attending a training or obtaining a certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse Providers for such costs.

1. Providers seeking reimbursement for completed training or certification, or both, approved under section 8.500.9.B.1.a.ii, must submit the following to the Department:

a. Supported Employment Providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-

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approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving a reimbursement request under section 8.500.14.H.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under section 8.500.9.B.1.a.ii.1.c and either notify the provider of the denial or, if approved, reimburse the provider.

a. Reimbursement is limited to the following amounts and includes reimbursement for wages:

i. Up to $300 per certification exam.

ii. Up to $1,200 for each training.

8.500.15 INDIVIDUAL RIGHTS

8.500.15.A Individual rights shall be in accordance with Sections 25.5-10-223 - 230., C.R.S.

8.500.16 APPEAL RIGHTS

The Case Management Agency shall meet the requirements set forth at Section 8.519.22.

8.500.16.A The CCB shall provide the long-term care notice of action form to applicants and MemberClients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq.* When:

1. The MemberClient or applicant is determined to not have a developmental disability,

2. The MemberClient or applicant is found eligible or ineligible for LTSS,

3. The MemberClient or applicant is determined eligible or ineligible for placement on a waiting list for LTSS,

4. An adverse action occurs that affects the MemberClient's or applicant's waiver enrollment status,

8.500.16.B The CCB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CCB has made a denial or adverse action against a MemberClient.

8.500.16.C The CCB shall notify the Case Management Agency in the MemberClient's service plan within one (1) business day of the adverse action.

8.500.16.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.16.E The applicant or MemberClient shall be informed of an adverse action if the MemberClient or applicant is determined ineligible and the following:

1. The MemberClient or applicant is detained or resides in a correctional facility, or

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2. The MemberClient or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

8.500.17 QUALITY ASSURANCE

8.500.17.A The monitoring HCBS-DD Waiver services and the health and well-being of service recipients shall be the responsibility of the Operating Agency, under the oversight of the Department.

8.500.17.B The Operating Agency, shall conduct reviews of each agency providing HCBS-DD waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department or Operating Agency. The review shall apply rules and standards developed for programs serving individuals with intellectual or developmental disabilities.

8.500.17.C The Operating Agency shall maintain or cause to be maintained for three years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-DD waiver programs or the delivery of services. The Department shall have access to these records at any reasonable time.

8.500.17.D The Operating Agency shall recommend to the Department the suspension of payment, denial or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond by submitting a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.17.E After having received the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action within a reasonable timeframe agreed upon the Department and the Operating Agency.

[SECTION 8.500.18 REMAINS UNCHANGED and IS UNAFFECTED BY THIS RULEMAKING]

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8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community-Based Supported Living Services (HCBS-SLS) waiver. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

HCBS-SLS services and supports which are available to assist persons with intellectual or developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an HCBS-SLS setting. HCBS-SLS waiver services are not intended to provide twenty-four (24) hours of paid support or meet all identified MemberClient needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-SLS waiver or a specific HCBS-SLS waiver service(s).

C. APPLICANT means as defined in Section 9.390.1.

D. AUTHORIZED REPRESENTATIVE means an individual designated by a MemberClient, or by the parent or guardian of the MemberClient receiving services, if appropriate, to assist the MemberClient receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.

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E. CASE MANAGEMENT AGENCY(CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

F. MEMBERCLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

G. MEMBERCLIENT REPRESENTATIVE means a person who is designated by the MemberClient to act on the MemberClient's behalf. A MemberClient representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or, (B) an individual, family member or friend selected by the MemberClient to speak for and/or act on the MemberClient's behalf.

H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

I CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

J. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-Based Services, and Medicaid State Plan Benefits including long-term home health services, and targeted case management.

K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the MemberClient.

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

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the MemberClient and includes the following:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a MemberClient with an intellectual or developmental disability has been given by a court; or,

A spouse; or

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The MemberClient's children.

Q. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

R. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

S HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a MemberClient who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

T. INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) for which the Department makes Medicaid payment under the Medicaid State Plan.

U. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a public or private facility that provides health and habilitation services to a MemberClient with intellectual or developmental disabilities or related conditions.

V. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the MemberClient's spouse.

W. LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a MemberClient must require in order to receive services in an institutional setting under the state plan.

X. LEVEL OF CARE SCREEN means as defined in Section 8.390.1.

Y. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illness who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

Z. MEDICAID ELIGIBLE means an Applicant or MemberClient meets the criteria for Medicaid benefits based on the Applicant's financial determination and disability determination when applicable.

AA. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the State covers, and how the State addresses additional Federal Medicaid statutory requirements concerning the operation of its Medicaid program.

BB. MEDICATION ADMINISTRATION means assisting a MemberClient in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

CC. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in a MemberClient's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

DD. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), Home and Community-Based Services

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Supported Living Services (HCBS-SLS) and Home and Community-Based Services Children's Extensive Support (HCBS-CES) waivers.

EE. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

FF. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent or the Case Management Agency.

GG. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

HH. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 et seq., that has received program approval to provide HCBS-SLS services.

II. PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use including vehicles for hire.

JJ. REIMBURSMENT RATES means the maximum allowable Medicaid reimbursement to a provider for each unit of service.

KK. RELATIVE means a person related to the MemberClient by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the MemberClient received services according to the PCSP and that the Case Management Agency complied with requirements set forth in statute, waiver and regulation.

MM. SERVICE DELIVERY OPTION means the method by which direct services are provided for a Member Client and include a) by an agency and b) MemberClient directed.

NN. SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the MemberClient's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of MemberClients in each level, and projected utilization.

OO. SUPPORT is any task performed for the MemberClient where learning is secondary or incidental to the task itself or an adaptation is provided.

PP. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi- structured interview of respondents who know the MemberClient well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

QQ. SUPPORT LEVEL means a numeric value determined using an algorithm that places MemberClients into groups with other MemberClients who have similar overall support needs.

RR. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; Assessment and periodic

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Reassessment, development and periodic revision of a PCSP referral and related activities, and monitoring.

SS. THIRD PARTY RESOURCES means services and supports that a MemberClient may receive from a variety of programs and funding sources beyond natural supports or Medicaid that may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

TT. WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State plan benefits.

8.500.91 HCBS-SLS WAIVER ADMINISTRATION

8.500.91.A HCBS-SLS shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities, 2 CCR 503-1 and promulgated in accordance with the provision of Section 25.5-6-404 (4), C.R.S.

8.500.91.B In the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the provisions of Section 25.5-6-404(4), C.R.S. shall apply and the regulations of the Department shall control.

8.500.10.C The HCBS-SLS waiver is operated by the the Department of Health Care Policy and Financing.

8.500.910.E HCBS-SLS services are available only to address those needs identified in the LOC Screen and authorized in the PCSP when the service or support is not available thr.ough the Medicaid State plan, EPSDT, natural supports, or third party payment resources.

8.500.91.F The HCBS-SLS Waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments into the HCBS-SLS waiver do not exceed the federally approved waiver capacity, and

4. May limit the enrollment when utilization of the HCBS-SLS waiver program is projected to exceed the spending authority.

8.500.92 GENERAL PROVISIONS

8.500.92.A The following provisions shall apply to the Home and Community-Based Services-Supported Living Services (HCBS-SLS) waiver:

1. HCBS-SLS shall be provided as an alternative to ICF-IID services for an eligible MemberClient with intellectual or developmental disabilities.

2. HCBS-SLS is waived from the requirements of Section 1902 (a)(10)(b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the State of Colorado.

3. A MemberClient enrolled in the HCBS-SLS waiver shall be eligible for all other Medicaid services for which the MemberClient qualifies and shall first access all benefits available under the Medicaid State plan or Medicaid EPSDT prior to accessing services under the HCBS-SLS waiver. Services received through the HCBS-SLS waiver may not duplicate services available through the State Plan

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8.500.93 MEMBERCLIENT ELIGIBILITY

8.500.93.A To be eligible for the HCBS-SLS waiver an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability

2. Be eighteen (18) years of age or older,

3. Does not require twenty-four (24) hour supervision on a continuous basis which is reimbursed as a HCBS-SLS service,

4. Is served safely in the community with the type or amount of HCBS-SLS waiver services available and within the federally approved capacity and cost containment limits of the waiver,

5. Meet ICF-IID level of care as determined by the LOC Screen.

6. Meet the Medicaid financial determination for LTC eligibility as specified at Section 8.100; and,

7. Reside in an eligible HCBS-SLS setting. SLS settings are the MemberClient's residence, which is defined as the following:

   a. A living arrangement, which the MemberClient owns, rents or leases in own name,

   b. The home where the MemberClient lives with the MemberClient's family or legal guardian, or

   c. A living arrangement of no more than three (3) persons receiving HCBS-SLS residing in one household, unless they are all members of the same family.

8. The MemberClient shall maintain eligibility by continuing to meet the HCBS-SLS eligibility requirements and the following:

   a. Receives at least one (1) HCB-SLS waiver service each calendar month,

   b. Is not simultaneously enrolled in any other HCBS waiver, and

   c. Is not residing in a hospital, nursing facility, ICF-IID, correctional facility or other institution.

9. When the HCBS-SLS waiver reaches capacity for enrollment, a MemberClient determined eligible for a waiver shall be placed on a wait list in accordance with these rules at Section 8.500.96.

8.500.94 HCBS-SLS WAIVER SERVICES

8.500.94.A. SERVICES PROVIDED

1. Assistive Technology

2. Behavioral Services

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3. Benefits Planning

4. Day Habilitation services and supports

5. Dental Services

6. Health Maintenance

7. Home Accessibility Adaptations

8. Home Delivered Meals

9. Homemaker Services

10. Life Skills Training (LST)

11. Mentorship

12. Non-Medical Transportation

13. Peer Mentorship

14. Personal Care

15. Personal Emergency Response System (PERS)

16. Professional Services, defined below in 8.500.94.B.14

17. Respite

18. Remote Supports

19. Specialized Medical Equipment and Supplies

20. Supported Employment

21. Transition Setup

22. Vehicle Modifications

23. Vision Services

24. Workplace Assistance

8.500.94.B 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 MemberClient to increase, maintain or improve functional capabilities. This may include assisting the MemberClient in the selection, acquisition, or use of an assistive technology device and includes:

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

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

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

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

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

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

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

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

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

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

i) Purchase, training or maintenance of service animals,

ii) Computers,

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

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

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

2. Benefits Planning is the analysis and guidance provided to a member and their family/support network to improve their understanding of the potential impact of employment-related income on the member's public benefits. Public benefits include, but are not limited to: Social Security, Medicaid, Medicare, food/nutrition programs, housing assistance, and other federal, state, and local benefits. Benefits Planning gives the member an opportunity to make an informed choice regarding employment opportunities or career advancement.

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a. Benefits Planning may only be provided by Certified Benefits Planners. A Certified Benefits Planner holds at least one of the following credentials:

i. Community Work Incentives Coordinator (CWIC);

ii. Community Partner Work Incentives Counselor (CPWIC);

iii. Credentialed Work Incentives Practitioner (WIP-CTM).

b. Documentation of the Benefits Planner's certification and additional trainings shall be maintained and provided upon request by a surveyor or the Department.

c. Certified Benefits Planners must obtain and sustain a working knowledge of Colorado's Medicaid Waiver system as well as federal, state, and local benefits.

d. If the Certified Benefits Planner encounters a benefit situation that is beyond their expertise, consultation with technical assistance liaisons is expected.

e. Benefits Planning is available regardless of employment history or lack thereof, and can be accessed throughout the phases of a member's career such as: when considering employment, changing jobs, or for career advancement/exploration. Certified Benefits Planners support members by providing any of these core activities:

i. Intensive individualized benefits counseling;

ii. Benefits verification;

iii. Benefit summary & analysis (BS&A);

iv. Identifying applicable work incentives, and if needed, developing a work incentive plan for the member and team;

v. In addition to the core activities, Benefits Planning may also be utilized to:

1) Conduct an informational meeting with the member, alone or with their support network.

2) Assist with evaluating job offers, promotional opportunities (increase in hours/wage), or other job changes that the member is considering which changes income levels; and outlining the impact that change may have on public benefits.

3) Provide information on Waiver benefits (including Buy-In options), federal/state/local programs, and other resources that may support the member in maintaining benefits while pursuing employment.

4) Assist with referrals and connecting the member with identified resources, as needed; as well as coordinating with member, Case Manager, family, and other team members to promote accessing services/resources that will advance the member's desired employment goals.

5) Navigate complicated benefit scenarios and offer problem-solving strategies, so that the member may begin or continue working while maintaining eligibility for needed services.

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6) Offer suggestions to the member and their family/support network regarding how to create and maintain a recordkeeping structure and reporting strategy related to benefit eligibility and requirements.

7) If the member needs assistance with the collection and submission of income statements and/or documentation related to the Social Security Administration (SSA), or other benefits managing organizations, and the member does not have other supports to do so, the Benefits Planner may assist on a temporary basis.

f. The Benefits Planning provider must maintain records which reflect the Benefits Planning activities that were completed for the member, including copies of any reports provided to the member.

g. In collaboration with the member's Case Manager and support team, a Benefits Planner can assist in accessing federal/state/local resources, evaluate the potential impact on benefits due to changes in income, and if there is a negative impact identified the Benefits Planner can help brainstorm alternatives to meet existing needs.

h. Benefits Planning shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.

i. Benefits Planning services are limited to forty (40) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

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

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

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

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

d. Behavioral Services:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Specialized habilitation (SH) services are provided to enable the MemberClient to attain the maximum functional level or to be supported in such a manner that allows

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the MemberClient to gain an increased level of self-sufficiency. Specialized habilitation services:

i) Include the opportunity for MemberClients to select from Age Appropriate Activities and Materials, as defined in Section 8.484.2.A., both within and outside of the setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

vi) Documentation shall be maintained in the file of each MemberClient receiving this service that the service is not available under a program funded under Section 110 of the rehabilitation act of 1973 or the Individuals with Educational Disabilities Act (20 U.S.C. Section 1400 *et seq.*).

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

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

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

a. Preventative services include:

i) Dental insurance premiums and co-payments

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

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

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

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

vi) Treatment of injuries, or

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vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

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

ii) Crowns

iii) Bridges

iv) Dentures

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

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

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

g. Full mouth implants or crowns are not covered.

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

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

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

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

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

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

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

c. Mouth care performed when:

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

ii) in the presence of communicable disease,

iii) the MemberClient is unconscious, or

iv) oral suctioning is required,

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

e. Feeding

i) When suctioning is needed on a stand-by or other basis,

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

iii) Syringe feeding, OR

iv) Feeding using an apparatus,

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

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

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

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

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

k. Respiratory care, including:

i. Postural drainage,

ii) Cupping,

iii) Adjusting oxygen flow within established parameters,

iv) Suctioning of mouth and nose,

v) Nebulizers,

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vi) Ventilator and tracheostomy care,

vii) Prescribed respiratory equipment.

8.500.94.B.6. HOME ACCESSIBILITY ADAPTATIONS

8.500.94.B.6.a DEFINITIONS

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

Case Manager means a person who provides case management services and meets all regulatory requirements for case managers.

The Division of Housing (DOH) is a division within the Colorado Department of Local Affairs that is responsible for approving Home Accessibility Adaptation PARs, oversight on the quality of Home Accessibility Adaptation projects, and inspecting Home Accessibility Adaptation projects, as described in these regulations.

1. DOH oversight is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, all oversight functions shall be performed by the Department unless specifically allowed by the Participant or their guardian to be performed by DOH.

Home Accessibility Adaptations means the most cost-effective physical modifications, adaptations, or improvements in a Participant's existing home setting which, based on the Participant's medical condition or disability: Participant

1. Are necessary to ensure the health and safety of the Participant;

2. Enable the Participant to function with greater independence in the home; or

3. Prevent institutionalization or support the deinstitutionalization of the Participant.

Home Accessibility Adaptation Provider means a provider agency that meets the standards for Home Accessibility Adaptation described in Section 8.500.94.B.6.e and is an enrolled Medicaid provider.

Person-Centered Planning means Home Accessibility Adaptations that are agreed upon through a process that is driven by the Participant and can include people chosen by the Participant, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations; and where the Participant is provided necessary information, support, and choice Participant to ensure that the Participant directs the process to the maximum extent possible.

8.500.94.B.6.b INCLUSIONS

8.500.94.B.6.b.i Home Accessibility Adaptations may include, but are not limited to the following:

a) Installing or building ramps;

b) Installing grab-bars or other Durable Medical Equipment (DME) if such installation cannot be performed by a DME supplier;

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c) Widening or modification of doorways;

d) Modifying a bathroom facility for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

e) Modifying a kitchen for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

f) Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies;,

g) Installing stair lifts or vertical platform lifts;

h) Modifying an existing second exit or egress window to lead to an area of rescue for emergency purposes;

i) The modification of a second exit or egress window must be approved by the Department or DOH at any funding level as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the Participant.

i) Safety enhancing supports such as basic fences, strengthened windows, and door and window alerts.

8.500.94.B.6.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of Section 8.500.94.B.6.

8.500.94.B.6.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.

8.500.94.B.6.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.

8.500.94.B.6.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.

a) Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the Participant, or enable the Participant to function with greater independence in the home, if:

i) The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and

ii) Either:

1. There is an immediate risk to the Participant's health or safety, or

2. There has been a significant change in the Participant's needs since a previous Home Accessibility Adaptation.

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b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule at Section 8.500.94.B.6.

8.500.94.B.6.c. EXCEPTIONS AND RESTRICTIONS

8.500.94.B.6.c.i. Home Accessibility Adaptations must be a direct benefit to the Participant and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.

8.500.94.B.6.c.ii. Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, are prohibited.

8.500.94.B.6.c.iii. Adaptations, improvements, or modifications as a part of new construction costs are prohibited.

a) Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.

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

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

ii) configure a bathroom to accommodate a wheelchair.

c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department requirements found in this rule at Section 8.500.94.B.6.

8.500.94.B.6.c.iv. The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.

8.500.94.B.6.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.

8.500.94.B.6.c.vi. Upgrades beyond what is the most cost-effective means of meeting the Participant's identified need, including, but not limited to items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

8.500.94.B.6.c.vii. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

a) Roof repair,

b) Central air conditioning,

c) Air duct cleaning,

d) Whole house humidifiers,

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e) Whole house air purifiers,

f) Installation or repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,

g) Monthly or ongoing home security monitoring fees,

h) Home furnishings of any type,

i) HOA fees.

8.500.94.B.6.c.viii. Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.

8.500.94.B.6.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.500.94.B.6.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.500.94.B.6.d CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.500.94.B.6.d.i. The Case Manager shall consider alternative funding sources to complete the Home Accessibility Adaptation. The alternatives considered and the reason they are not available shall be documented in the case record.

1) The Case Manager must confirm that the Participant is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding. Case Managers may request confirmation of a property owner's obligations through DOH.

8.500.94.B.6.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval and confirmation of Home Accessibility Adaptation fund availability.

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8.500.94.B.6.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization Request form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6. Home Accessibility Adaptations submitted with improper documentation will not be approved.

2) The Case Manager and CMA are responsible for retaining and tracking all documentation related to a Participant's Home Accessibility Adaptation funding use and communicating that information to the Participant and Home Accessibility Adaptation providers. The Case Manager may request confirmation of a Participant's Home Accessibility Adaptation fund use from the Department or DOH.

3) The Case Manager shall discuss any potential plans to move to a different residence with the Participant or their guardian and advise them on the most prudent utilization of available funds.

8.500.94.B.6.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1) An occupational or physical therapist (OT/PT) shall assess the Participant's needs and the therapeutic value of the requested Home Accessibility Adaptation. When an OT/PT with experience in Home Accessibility Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Accessibility Adaptation would contribute to a Participant's ability to remain in or return to his/her home, and how the Home Accessibility Adaptation would increase the Participant's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

a) The evaluation must be performed in the home to be modified. If the Participant is unable to access the home to be modified without the modification, the OT/PT must evaluate the Participant and home separately and document why the Participant was not able to be evaluated in the home.

2) The evaluation may be provided by a home health agency or other qualified and approved OT/PT through the Medicaid Home Health benefit.

a) A Case Manager may initiate the OT/PT evaluation process before the Participant has been approved for waiver services, as long as the Participant is Medicaid eligible.

b) A Case Manager may initiate the OT/PT evaluation process before the Participant physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

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c) OT/PT evaluations performed by non-enrolled Medicaid providers may be accepted when an enrolled Medicaid provider is not available. A Case Manager must document the reason why an enrolled Medicaid provider is not available.

3) The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Participant's needs. The Case Manager shall document these alternatives and why they did not meet the Participant's needs in the Participant's case file.

8.500.94.B.6.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:

1) The Case Manager shall assist the Participant in soliciting bids from at least two Home Accessibility Adaptation Providers for Home Accessibility Adaptations estimated to cost $2,500 or more. Participant choice of provider shall be documented throughout.

2) The Case Manager must verify that the provider is an enrolled Home Accessibility Adaptation Provider for Home Accessibility Adaptations.

4) The bids for Home Accessibility Adaptations at all funding levels shall include a breakdown of the costs of the project and the following:

a) Description of the work to be completed,

b) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour,

c) Estimate for building permits, if needed,

d) Estimated timeline for completing the project,

e) Name, address and telephone number of the Home Accessibility Adaptation Provider,

f) Signature, physical or digital, of the Home Accessibility Adaptation Provider,

g) Signature, physical or digital, or other indication of approval, such as email approval, of the Participant or their guardian, that indicates all aspects of the bid have been reviewed with them,

h) Signature, physical or digital of the home owner or property manager if the home is not owned by the Participant or their guardian.

5) Home Accessibility Adaptation Providers have a maximum of thirty (30) days to submit a bid for the Home Accessibility Adaptation project after the Case Manager has solicited the bid.

a) If the Case Manager has made three attempts to obtain a bid from a second Home Accessibility Adaptation Provider

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and the provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

6) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.500.94.B.6. and the recommendations of the OT/PT evaluation.

a) If a Participant or homeowner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

7) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.500.94.B.6.

8.500.94.B.6.d.vi. If a property to be modified is not owned by the Participant, the Case Manager shall obtain physical or digital signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein.

1) Written consent of the homeowner or property manager is required for all projects that involve permanent installation within the Participant's residence or installation or modification of any equipment in a common or exterior area.

2) The authorization shall include confirmation that the home owner or property manager agrees that if the Participant vacates the property, the Participant may choose to either leave the modification in place or remove the modification, that the home owner or property manager may not hold any party responsible for removing all or part of a Home Accessibility Adaptation project, and that if the Participant chooses to remove the modification, the property must be left in equivalent or better than its pre-modified condition.

8.500.94.B.6.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation, the Department may hold the CMA financially liable for the increased cost.

8. 500.94.B.6.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR. Visit may be completed using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk (e.g. natural disaster, pandemic, etc.).

8.500.94.B.6.e PROVIDER RESPONSIBILITIES

8.500.94.B.6.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in Section 8.500.98.

8.500.94.B.6.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the Home Accessibility Adaptation services will be performed, if required by that city or county.

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8.500.94.B.6.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

1) If any changes to the approved scope of work are made without DOH or Department authorization, the cost of those changes will not be reimbursed.

2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi

8.500.94.B.6.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's expense.

1) The provider shall give the Participant or their guardian all manufacturer's or seller's warranties on completion of work.

8.500.94.B.6.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications (2018) developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8.500.94.B.6.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Accessibility Adaptation projects may be inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. Participants must provide access for inspections.

1) DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion for sampled projects, or receipt of a Participant's reasonable request.

2) DOH shall produce a written inspection report within the time frame agreed upon in the Home Accessibility Adaptations work plan that notes the Participant's specific complaints. The inspection report shall be sent to the Participant, Case Manager, and provider.

3) Home Accessibility Adaptation Providers must repair or correct any noted deficiencies within twenty (20) days or the time required in the inspection report, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline and be supported by documentation, including Participant notification. Reimbursement

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may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

8.500.94.B.6.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis for non-payment or recovery of payment by the Department.

1) Volunteer work on a Home Accessibility Adaptation project approved by the Department shall be completed under the supervision of the Home Accessibility Adaptation Provider as stated on the bid.

a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family of the Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

8.500.94.B.6.f REIMBURSEMENT

8.500.94.B.6.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments.

8.500.94.B.6.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8.500.94.B.6.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation to DOH:

1) Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2) Required permits;

3) One-year written warranty on materials and labor; and

4) Documentation in the Participant's file that the Home Accessibility Adaptation has been completed satisfactorily through:

a) Receipt of the inspection report approving work from the state, county, or local building, plumbing, or electrical inspector;

b) Approval by the Participant, representative, or other designee;

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c) Approval by the homeowner or property manager;;

d) A final on-site inspection report by DOH or its designated inspector; or

e) DOH acceptance of photographs taken both before and after the Home Accessibility Adaptation.

8.500.94.B.6.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8.500.94.B.6.f.v. The Home Accessibility Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.

1) All required repairs noted on inspections shall be completed before the Home Accessibility Adaptation Provider submits a final claim for reimbursement.

2) If a Home Accessibility Adaptation Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the provider during an inspection. The provider shall only be reimbursed for the value of the work completed satisfactorily.

a) A Home Accessibility Adaptation Provider may request DOH perform one (1) reconsideration of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the provider's expense.

8.500.94.B.6.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.

1) Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 7 day deadline and be supported by documentation, including Participant notification.

2) The Home Accessibility Adaptation reimbursement reduced pursuant to this subsection shall be considered part of the Participant's remaining funds.

8.500.94.B.6.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

8. Home Delivered Meals as defined at Section 8.553.1.

9. Homemaker services are provided in the MemberClient's home and are allowed when the MemberClient's disability creates a higher volume of household tasks or requires that

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household tasks are performed with greater frequency. There are two types of homemaker services:

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

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

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

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

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

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

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

2) To increase the independence of the MemberClient,

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

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

10. Life Skills Training (LST) as defined at Section 8.553.1.

11. Mentorship services are provided to MemberClients 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 MemberClients who are parenting children.

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

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

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g. Units to provide training to MemberClients 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.

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

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

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

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

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

13. Peer Mentorship as defined at Section 8.553.

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

a. Personal care services include:

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

ii) Assistance with money management,

iii) Assistance with menu planning and grocery shopping, and

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

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

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

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

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ii. The MemberClient shall be informed of the option to direct his/her health maintenance activities pursuant to Section 8.510, et seq.

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

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

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

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

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

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

d. Professional services may be reimbursed only when:

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

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

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

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

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

i) Acupuncture,

ii) Chiropractic care,

iii) Fitness trainer

iv) Equine therapy,

v) Art therapy,

vi) Warm water therapy,

vii) Experimental treatments or therapies, and.

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viii) Yoga.

17. Respite service is provided to MemberClients on a short-term basis, because of the absence or need for relief of the primary caregivers of the MemberClient.

a. Respite may be provided:

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

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

iii) In the community.

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

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

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

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

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

c. The following limitations to respite services shall apply:

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

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

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

18. Remote Supports means services as defined at Section 8.488

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

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

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

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

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

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

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

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

b. Supported employment may be delivered in a variety of settings in which MemberClients have the opportunity to interact regularly with individuals without disabilities, other than those individuals who are providing services to the MemberClient.

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

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

e. Group employment including mobile crews shall not exceed eight MemberClients.

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

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

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

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

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

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

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

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

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

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

m. If a member is employed, the supervision the member needs while at work shall be clearly documented in their Person-Centered Support Plan (PCSP). A member's supervision level at work must be based on the member's specific work-related support needs.

i) The level of supervision by paid caregivers may be lower at work than in other community settings, and the member should not be over-supported or limited in their availability to work based on supervision needs identified for other settings.

21. Transition Setup as defined at Section 8.553.1.

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

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

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

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

ii) Purchase or lease of a vehicle, and

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

c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall ensure the health and safety of the MemberClient, enable the MemberClient to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the

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current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.

23. 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 MemberClient who is at least 21 years of age

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

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

c. Prior authorized in accordance with Operating Agency procedures.

24. Workplace Assistance services provide work-related supports for members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver that is above and beyond what could be regularly supported by the workplace supervisor, co-workers, or job coach, in order to maintain an individual job in an integrated work setting for which the member is compensated at or above minimum wage. Training/Job Coaching, accommodations, technology, and natural supports are to be used to maximize the member's independence and minimize the need for the consistent presence of a paid caregiver. As such, the degree to which the member must be supported by a paid caregiver through the Workplace Assistance service, shall be based on the specific safety-related need(s) identified in the person-centered planning process for the member at their worksite.

a. Workplace Assistance:

i. is provided on an individual basis, not within a group, and cannot overlap with job coaching;

ii. occurs at the member's place of employment, during the member's work hours, and when needed may also be used:

1) immediately before or after the member's employment hours,

2) during work-related events at other locations;

iii. includes but is not limited to: promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs, redirecting, reminding to follow work-related protocols/ strategies, and ensuring other identified needs are met so the member can be integrated and successful at work;

iv. may include activities beyond job-related tasks that support integration at work, such as assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events.

b. Workplace Assistance is appropriate for and available to:

i. Members who require Intensive Supervision or have a documented need which warrants a Rights Modification requiring extensive supervision, such as, a court order or the member meeting Public Safety Risk or Extreme Risk-to-Self criteria pursuant to Section 8.612.5(i) definitions.

ii. Members whose support team agrees there is justification for a paid caregiver to be present for a portion of the hours worked due to safety

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concerns; and those needs are beyond what could be addressed through natural supports, technology, or intermittent Job Coaching.

1) The specific safety concerns identified by members and their support teams may include, but are not limited to:

a) regularly demonstrating behaviors that cause direct harm to themselves or others;

b) intentionally or unintentionally putting themselves in unsafe situations frequently;

c) often demonstrating poor safety awareness or making poor decisions related to personal safety.

2) A member's supervision level is not the sole factor which justifies the need for this service, therefore, the supervision level shall not be elevated in order to access the service. The member's supervision level at the worksite shall be based on actual need related to the member at work.

c. Prior to Workplace Assistance being authorized, including at the Person-Centered Support Plan's annual renewal, the member and their support team shall determine that alternatives to paid caregiver supports were fully explored, by considering the factors listed below. Documentation of these considerations shall be reflected in the member's Case Management record.

i. Job Coaching services have been or will be leveraged to promote the member's independence and minimize the need for the presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, promoting natural supports, integrating technology, and using systematic instruction techniques.

ii. The specific safety concern(s) to be addressed and how the Workplace Assistance staff could support the member in addressing the safety concerns while facilitating integration and independence at work.

iii. The nature of the job and work location, the member's longevity with the employer, the degree of continuity at the member's place of employment, and the likelihood of the member putting themselves/others in harm's way, despite training, technology, and cues from natural supports.

iv. The member's desire to have a paid caregiver present for the identified time periods.

v. The Supported Employment provider's informed opinion regarding the need for paid caregiver support beyond intermittent Job Coaching. This opinion should be grounded in Employment First concepts as evidenced by:

1) The provider's completion of a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification); or

2) If the Supported Employment provider does not possess this credentialing, then the Supported Employment provider or the Case Manager may consult with:

a) by someone who does possess either a Training Certificate or Certification

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b) or a representative from the Department of Health Care Policy and Financing who oversees the Workplace Assistance benefit.

d. Workplace Assistance staff shall consistently seek to promote the member's independence and integration at work.

i. Where possible, efforts should be made to reduce or eliminate the need for Workplace Assistance services over time, and the efforts and progress shall be documented by the provider.

ii. The training for Workplace Assistance staff should:

1) include fundamentals of Employment First principles with emphasis on promoting independence and inclusion;

2) provide insight regarding a paid caregiver's role at a member's place of employment such that the Workplace Assistance staff's presence does not hinder the member's interaction with co-workers, customers, and other community members.

8.500.94.C PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES

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

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

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

i) Personal Care as defined at Section 8.500.94.B.12

ii) Homemaker services as defined at Section 8.500.94.B.8

iii) Health Maintenance Activities as defined at Section8.500.94.B.5

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

8.500.95 SERVICE PLAN:

The Case Management Agency shall complete a service plan for each MemberClient enrolled in the HCBS-SLS waiver in accordance with Section 8.519.11.B.2

8.500.95.D The Service Plan must be reported in the Department prescribed system and include the following employment information for individuals eligible for or receiving Supported Employment services, if applicable:

1. Sector and type of employment.

2. Mean wage per hour earned.

3. Mean hours worked per week.

8.500.96 WAITING LIST PROTOCOL

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8.500.96.A When the federally approved waiver capacity has been met, persons determined eligible to receive services under the HCBS-SLS, shall be eligible for placement on a waiting list for services.

8.500.96.B Waiting lists for persons eligible for the HCBS-SLS waiver program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Operating Agency's procedures.

8.500.96.C Persons determined eligible shall be placed on the waiting list for services in the Community Centered Board service area of residency.

8.500.96.D Persons who indicate a serious intent to move to another service area should services become available shall be placed on the waiting list in that service area. Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in the Operating Agency's procedures for placement on a waiting list in a service area other than the area of residency.

8.500.96.E The date used to establish a person's placement on a waiting list shall be:

1. The date on which eligibility for developmental disabilities services in Colorado was originally determined; or

2. The fourteenth (14th) birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

8.500.96.F As openings become available in the HCBS-SLS waiver program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:

1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered and the emergency cannot be resolved in another way. Emergencies are defined as follows:

a. Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode.

b. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

c. Danger to Others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

d. Danger to Self: a person's medical, psychiatric or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

e. The Legislature has appropriated funds specific to individuals or to a specific class of persons.

f.. If an eligible individual is placed on a waiting list for SLS waiver services, a written notice, including information regarding the MemberClient appeals process, shall be sent to the individual and/or his/her legal guardian in accordance with the provisions of Section 8.057, *et seq*.

8.500.97 MEMBERCLIENT RESPONSIBILITIES

8.500.97.A A MemberClient or the MemberClient's family or guardian is responsible for:

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1. Providing accurate information regarding the MemberClient's ability to complete activities of daily living,

2. Assisting in promoting the MemberClient's independence,

3. [no text]

4. Cooperating in the determination of financial eligibility,

5. Notifying the case manager within thirty (30) days after:

   a. Changes in the MemberClient's support system, medical condition and living situation including any hospitalizations, emergency room admissions,

   b. Placement to a nursing home or intermediate care facility for the individuals with intellectual disabilities (ICF-IID),

   c. The MemberClient has not received an HCBS waiver service during one (1) month

   d. Changes in the MemberClient's care needs,

   e. Problems with receiving HCBS-SLS waiver services, and

   f. Changes that may affect Medicaid financial eligibility including prompt report of changes in income or assets.

8.500.98 PROVIDER REQUIREMENTS

8.500.98.A A private for profit or not for profit agency or government agency shall meet minimum provider qualifications as set forth in the HCBS-SLS waiver and shall:,

1. Conform to all state established standards for the specific services they provide under HCBS-SLS,

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in Section 8.130,

4. Discontinue HCBS-SLS services to a MemberClient only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

5. Have written policies governing access to duplication and dissemination of information from the MemberClient's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S.

6. When applicable, maintain the required licenses from the Colorado Department of Public Health And Environment, and

7. Maintain MemberClient records to substantiate claims for reimbursement according to Medicaid standards.

8.500.98.B HCBS-SLS providers shall comply with:

1. All applicable provisions of Title 27, Article 10.5, C.R.S., and the rules and regulations as set forth in Section 8.600.

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2. All federal program reviews and financial audits of the HCBS-SLS waiver services,

3. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,

4. Requests from the county Departments of Social/Human Services to access records of MemberClients receiving services held by case management agencies as required to determine and re-determine Medicaid eligibility;

5. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-SLS waiver, and

6. Requests by the case management agency to monitor service delivery through targeted case management activities.

8.500.98.C Supported Employment provider training and certification requirements

1. Supported Employment service providers, including Supported Employment professionals who provide individual competitive integrated employment, as defined in 34 C.F.R. 361.5(c)(9) (2018), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and certification requirements. The incorporation of 34 C.F.R. 361.5(c)(9) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103 (12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of the incorporated material will be provided at cost upon request.

a. Subject to the availability of appropriations for reimbursement in section 8.500.104.G, Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

i. Deadlines.

1) Existing staff, employed by the Provider on or before July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

2) Newly hired staff, employed by the Provider after July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

a) Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

ii. Department approval required.

1) The Training Certificate or Certification required under section 8.500.98.C.1.a must be pre-approved by the Department.

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a) Providers must submit the following information to the Department for pre-approval review:

i) Provider name.

ii) A current Internal Revenue Service Form W-9.

iii) Seeking approval for:

1. Training Certificate, or

2. Certification, or

3. Training Certificate and Certification.

iv) Name of training, if applicable, including:

1. Number of staff to be trained.

2. Documentation that the training is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

v) Name of Certification, if applicable, including:

1. Number of staff to receive Certification.

2. Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

vi) Dates of training, if applicable, including:

1. Whether a certificate of completion is received.

vii) Date of Certification exam, if applicable.

b) Department approval will be based on alignment with the following core competencies:

i) Core values and principles of Supported Employment, including the following:

1. The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.

ii) The Person-centered process, including the following:

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1. The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-centered approach includes working with a team where the individual chooses the people involved on the team and receives: necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.

iii) Individualized career assessment and planning, including the following:

1. The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.

iv) Individualized job development, including the following:

1. Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.

v) Individualized job coaching, including the following:

1. Providing necessary workplace supports to MemberClients with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.

vi) Job Development, including the following:

1. Effectively engaging employers for the purpose of community job development for MemberClients with significant disabilities, which meets the needs of both the employer and the MemberClient.

c) The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and notify the Provider of its determination within 30 days of receiving the pre-approval request under 8.500.98.C.1.a.ii.1.a.

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8.500.99 TERMINATION OR DENIAL OF HCBS-SLS MEDICAID PROVIDER AGREEMENTS

8.500.99.A The Department may deny or terminate an HCBS-SLS Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at Section 8.130 et seq,

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-SLS services,

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider,

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper MemberClient notification,

5. Emergency termination of any provider agreement shall be in accordance with procedures at Section 8.050, and

8.500.99.B The provider fails to comply with requirements for submission of claims pursuant to Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

8.500.100 ORGANIZED HEALTH CARE DELIVERY SYSTEM

8.500.100.A The Organized Health Care Delivery System (OHCDS) for the HCBS-SLS waiver is the Community Centered Board as designated by the Operating Agency in accordance with Section 27-1010.5-103,.

8.500.100.B The OHCDS is the Medicaid provider of record for a MemberClient whose services are delivered through the OHCDS,

8.500.100.C The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS according to the current federally approved waiver.

8.500.100.D The OHCDS may contract or employ for delivery of HCBS Waiver services.

8.500.100.E The OCHDS shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS Waiver,

2. Ensure that services are delivered according to the waiver definitions and as identified in the MemberClient's service plan,

3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

4. Monitor the health and safety for HCBS MemberClients receiving services from a subcontractor.

8.500.100.F The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

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1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to MemberClients,

4. Negotiate rates that are in accordance with the Operating Agency's established fee for service rate schedule and Operating Agency procedures,

   a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

5. Collect and maintain the data used to develop provider rates and ensure data includes costs for services to address the MemberClient's needs, that are allowable activities within the HCBS service definition and that supports the established rate,

6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency or Centers for Medicare and Medicaid Services (CMS), and

7. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.500.101 PRIOR AUTHORIZATION REQUESTS

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14

[SECTION 8.500.102 REMAINS UNCHANGED AND IS UNAFFECTED BY THIS RULEMAKING]

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8.500.103 RETROSPECTIVE REVIEW PROCESS

8.500.103.A Services provided to a MemberClient are subject to a retrospective review by the Department and the Operating Agency. This retrospective review shall ensure that services:

1. Identified in the PCSP are based on the MemberClient's identified needs as stated in the LOC Screen.

2. Have been requested and approved prior to the delivery of services,

3. Provided to a MemberClient are in accordance with the PCSP and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

8.500.103.B When the retrospective review identifies areas of non compliance, the case management agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.103.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

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8.500.103.D When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status

8.500.104 PROVIDER REIMBURSEMENT

8.500.104.A Providers shall submit claims directly to the Department's fiscal agent through the Medicaid management information system (MMIS); or through a qualified billing agent enrolled with the Department's fiscal agent.

8.500.104.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally approved HCBS-SLS waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance with the frequency, amount, scope and duration of the service as identified in the MemberClient's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.104.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.104.D When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.104.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claim submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.104.F Except where otherwise noted, payment is based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin accessed through the Department's fiscal agent's web site.

8.500.104.G Reimbursement for Supported Employment Training Certificate or Certification, or both, under section 8.500.98.C.1.a, which includes both the cost of attending a training or obtaining a certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse providers for such costs.

1. Providers seeking reimbursement for a completed Training Certificate or Certification approved under section 8.500.98.C.1.a.ii.1.c must submit the following to the Department:

a. Supported Employment Providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.

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2. Within 30 days of receiving documentation under section 8.500.104.G.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under Section 8.500.98.C.1.a.ii and either notify the Provider of the denial or, if approved, reimburse the Provider.

a. Reimbursement is limited to the following amounts, and includes wages:

ii. Up to $300 per certification exam.

iii. Up to $1,200 for each training.

8.500.105 INDIVIDUAL RIGHTS

8.500.105.A The rights of a MemberClient in the HCBS-SLS Waiver shall be in accordance with Sections 27-10.5-112 through 131, C.R.S.

8.500.106 APPEAL RIGHTS

Case Management Agencies shall meet the requirements set forth at Section 8.519.22

8.500.106.A The CMACB shall provide the long-term care notice of action form to applicants and MemberClients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq*. when:

1. The MemberClient or applicant is determined to not have a developmental disability,

2. The MemberClient or applicant is found eligible or ineligible for LTSS,

3. The MemberClient or applicant is determined eligible or ineligible for placement on a waiting list for LTSS,

4. An adverse action occurs that affects the MemberClient's or applicant's waiver enrollment status; or,

8.500.106.B The CMACB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CMACB has made a denial or other adverse action against a MemberClient or applicant.

8.500.106.C The CMACB shall notify the Case Management Agency in the MemberClient's service plan within one (1) business day of the adverse action.

8.500.106.D The CMACCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.106.E The applicant or MemberClient shall be informed of an adverse action if the MemberClient is determined ineligible and the following:

1. The MemberClient or applicant s detained or resides in a correctional facility, or

2. The MemberClient or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

8.500.107 QUALITY ASSURANCE

8.500.107.A. The monitoring of services provided under the HCBS-SLS waiver and the health and well-being of MemberClients shall be the responsibility of the Operating Agency, under the oversight of the Department.

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8.500.107.B. The Operating Agency shall conduct on-site surveys or cause to have on-site surveys to be done in accordance with guidelines established by the Department or the Operating Agency. The survey shall include a review of applicable Operating Agency rules and regulations and standards for HCBS-SLS.

8.500.107.C The Operating Agency, shall ensure that the case management agency fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.

8.500.107.D The Operating Agency, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials which pertain to the operation and service delivery of the SLS waiver program.

8.500.107.E The Operating Agency shall recommend to the Department the suspension of payment denial or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.107.F After receiving the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action.

[SECTION 8.500.108 REMAINS UNCHANGED AND IS UNAFFECTED BY THIS RULEMAKING]

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8.501 State Funded Supported Living Services Program

The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide supports to individuals with an intellectual or developmental disability to remain in their community. The State-SLS program shall not supplant Home and Community-Based services for those who are currently eligible.

8.501.A Definitions

1. APPLICANT means an individual who is seeking supports from State-SLS program.

2. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to section 25.5-10-209.5, C.R.S., has a valid provider participation agreement with the Department, and has a valid contract with the Department to provide these services.

3. CCB CASE MANAGER means the staff member of the Community Centered Board that works with individuals seeking services to develop and authorize services under the State-SLS program.

4. MEMBERCLIENT means an individual who meets the DD Determination criteria and other State-SLS eligibility requirements and has been approved for and agreed to receive services in the State-SLS program.

5. MEMBERCLIENT REPRESENTATIVE means a person who is designated by the MemberClient to act on the MemberClient's behalf. A MemberClient Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, or a spouse; or (B) an individual, family member or friend selected by the MemberClient to speak for or act on the MemberClient's behalf.

6. CORRECTIVE ACTION PLAN means a written plan, which includes the detailed description of actions to be taken to correct non-compliance with State-SLS requirements, regulations,

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and direction from the Department, and includes the date by which each action shall be completed and the individuals responsible for implementing the action.

7. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not for-profit that meets the requirements set forth in Section 25.5.-10-209, C.R.S. and is responsible for conducting level of care evaluations and determinations for State-SLS services specific to individuals with intellectual and developmental disabilities.

8. COMMUNITY RESOURCE means services and supports that a MemberClient may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to, services provided through private insurance, non-profit services and other government programs.

9. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the MemberClient.

10. DEVELOPMENTAL DISABILITY (DD) DETERMINATION means the determination of a Developmental Disability as defined in section 8.607.2

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

12. DEVELOPMENTAL DISABILITY means a disability that is defined in section 8.600.4.

13. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).

14. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a MemberClient who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

15. LONG-TERM CARE SERVICES AND SUPPORTS (LTSS) means the services and supports utilized by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

16. MEDICAID ELIGIBLE means an Applicant or MemberClient meets the criteria for Medicaid benefits based on a financial determination and disability determination.

17. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses federal Medicaid statutory requirements concerning the operation of its Medicaid program.

18. NATURAL SUPPORTS means an informal relationship that provides assistance and occurs in the MemberClient's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

19. PERFORMANCE AND QUALITY REVIEW means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by the CCB to ensure quality and compliance with all statutory and regulatory requirements.

20. PLAN YEAR mean a twelve (12) month period starting from the date when State-SLS Supports and Services where authorized.

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21. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent.

22. PROGRAM APPROVED SERVICE AGENCY (PASA) means a developmental disabilities service agency or a service agency as defined in 8.602, that has received program approval, by the Department, to provide Medicaid Wavier services.

23. RELATIVE means a person related to the MemberClient by virtue of blood, marriage, or adoption.

24. RETROSPECTIVE REVIEW means the Department's review after services and supports are provided and the PASA is reimbursed for the service, to ensure the MemberClient received services according to the PCSP and standards of economy, efficiency and quality of service.

25. STATE-SLS INDIVIDUAL SUPPORT PLAN means the written document that identifies an individual's need and specifies the State-SLS services being authorized, to assist a MemberClient to remain safely in the community.

26. STATE FISCAL YEAR means a 12-month period beginning on July 1 of each year and ending June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in the calendar year.

27. Services and Supports or Supports and Services means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided to

    a. To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience person security and self-respect.

28. SUPPORT SERVICE means the service(s) established in the State SLS program that a CCB Case Manager may authorize to support an eligible MemberClient to complete the identified tasks identified in the MemberClient's Individualized Support Plan.

29. WAIVER SERVICE means optional services and supports defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.501.2 Administration:

1. The CCB shall administer the State-SLS program according to all applicable statutory, regulatory and contractual requirements, and Department policies and guidelines.

    a. The CCB is responsible for providing case management to all individuals enrolled in the State-SLS program.

    b. The CCB shall have written procedures related to the administration, case management, service provision, and waiting list for the State-SLS program.

    c. All records must be maintained in accordance with section 8.130.2.

    d. The CCB shall maintain a waiting list of eligible individuals for whom Department funding is unavailable in accordance with section 8.501.7.

    e. The CCB shall develop procedures for determining how and which individuals on the waiting list will be enrolled into the State-SLS program that comply with all applicable statutory, regulatory and contractual requirements including section 8.501.7.

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f. Any decision to modify, reduce or deny services or supports set forth in the State SLS program, without the Individual's or Guardian's agreement, are subject to the requirements in Section 8.605.

2. Eligibility

a. General Eligibility requirements

i. Individuals must be a resident of Colorado;

ii. Be eighteen (18) years of age or older; and

iii. Be determined to have an intellectual or developmental disability pursuant to the procedures set forth in section 8.607.2.

b. Eligibility for the State-SLS program does not guarantee the availability of services and supports under this program.

3. General Provisions

a. The availability of services offered through the State-SLS program may not be consistent throughout the State of Colorado or between CCBs.

b. An individual enrolled in the State-SLS program shall access all benefits available under the Medicaid State Plan, HCBS Waiver or EPSDT, if available, prior to accessing services under the State-SLS program. Services through the State-SLS program may not duplicate services provided through the State Plan when available to the Client.Member

c. Evidence of attempts to utilize all other public benefits and available and accessible community resources must be documented in the State-SLS individualized Support Plan by the CCB Case Manager, prior to accessing State-SLS services or funds.

d. The State-SLS program shall be subject to annual appropriations by the Colorado General Assembly.

e. These regulations shall not be construed to prohibit or limit services and supports available to persons with intellectual and developmental disabilities that are authorized by other state or federal laws.

f. When an individual is enrolled only in the State-SLS program the CCB Case Manager shall authorize a Program Approved Service Agency (PASA) to deliver the services, when available.

g. When a PASA is not available the CCB Case Manager may authorize and provide the Support Service, through the State-SLS program, to assist the MemberClient with tasks identified in his or her Individual Support Plan.

h. The CCB Case Manager may authorize Services and Supports from multiple State-SLS service categories at once, unless otherwise stated.

i. Unless otherwise specified, State-SLS Services and Supports may be utilized in combination with other Community Resources and/or Medicaid Services and Supports, as long as they are not duplicative, and all other available and accessible resources are utilized first.

4. Performance and Quality Review

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a. The Department shall conduct a Performance and Quality Review of the State-SLS program to ensure that the CCB is in compliance with all statutory and regulatory requirements.

b. A CCB found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but not limited to:

i. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;

ii. A detailed time-frame for completing the actions to be taken;

iii. The employee(s) responsible for implementing the actions; and

iv. The estimated date of completion.

c. The CCB shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The CCB shall explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.

i. Upon receipt of the proposed Corrective Action Plan, the Department will notify the CCB in writing whether the Corrective Action Plan has been accepted, modified, or rejected.

ii. In the event that the Corrective Action Plan is rejected, the CCB shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

iii. The CCB shall begin implementing the Corrective Action Plan upon acceptance by the Department.

iv. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.501.3 CCB and PASA Reimbursement

1. A PASA must submit all claims, payment requests, and/or invoices to the CCB for payment within thirty (30) days of the date of service, except for Services and Supports rendered in June, the last month of the State Fiscal Year. All claims, payment requests, and/or invoices for Services and Supports rendered in June must be submitted by the date specified by the CCB to ensure payment.

2. CCBs must submit all claims, payment requests, and/or invoices in the format and timeframe established by the Department.

3. CCB's and PASA's claims, payment requests, or invoices for reimbursement shall be made only when the following conditions are met:

a. Services and Supports are provided by a qualified PASA.

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b. Services and Supports are authorized and delivered in accordance with the frequency, amount, scope and duration of the service as identified in the MemberClient's State-SLS Individual Support Plan;

c. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the State-SLS Individual Support Plan and in accordance with the service definition;

d. All case management activities must be documented and maintained by the CCB.

1. CCBs and PASAs shall maintain records in accordance with Section 8.130.2.

2. CCB and PASA reimbursement shall be subject to review by the Department and may be completed after the payment has been made to the CCB and PASA. CCBs and PASAs are subject to all program integrity requirements in accordance with section 8.076.

3. The reimbursement for this service shall be established in the Department's published fee schedule.

4. Except where otherwise noted, PASA reimbursement shall be based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private PASAs and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the PASA bulletin and can be accessed through the Department's fiscal agent's web site.

a. State-SLS rates shall be set and published in the provider bulletin annually each State Fiscal Year.

8.501.4 State-SLS Covered Services and Supports

8.501.4.A. Supports for Individuals waiting for HCBS waiver enrollment.

1. Eligible MemberClients may receive the following Services and Supports

a. All Services and Supports identified in the HCBS-SLS waiver identified in section 8.500.94

b. Service limitations in the HCBS-SLS waiver and set forth in section 8.500 apply to the State-SLS program.

c. When a PASA is not available to provide Supports and Services the CCB may authorize the Support Services, to provide the needed Supports and Services identified in the State-SLS Individual Support Plan.

8.501.4.B Supports for Individuals Experiencing Temporary Hardships

1. State-SLS may be utilized to provide the following temporary Supports and Services to Individuals who have been determined to meet the criteria for an Intellectual / Developmental Disability as specified in Section 8.607.2, in situations where temporary assistance can alleviate the need for a higher level of care. These Services and Supports cannot be duplicative and shall not be accessed if available through other sources. In order to access State-SLS, an Individual Support Plan must be completed.

a. Payment of utilities:

i. Paying gas/electric bills and/or water/sewer bills:

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Documentation must be maintained by the CCB that all alternative programs, community support, and Natural Supports were utilized before any State-SLS funds were authorized.

b. Supports with acquiring emergency food, at a retail grocery store when there are no other community resources available

i. Documentation must be maintained by the CCB demonstrating the reason why State-SLS funds were utilized over other sources of emergency food. This may include but is not limited to:

1) Other emergency food programs are not available.

2) Home delivered meals have unexpectedly stopped.

c. Pest infestation abatement:

i. Documentation must be maintained by the Case Manager showing that infestation abatement is not covered under the MemberClient's residential agreement or lease.

ii. Documentation that the pest abatement professional is licensed in the state of Colorado, must be maintained by the CCB and provided to the Department upon request.

iii. Pest infestation abatement shall not be authorized if the MemberClient resides in a PASA owned and/or controlled property.

iv. Documentation showing proof of payment must be maintained by the CCB administering the State-SLS program;

2. Service Limitations

a. Support for utilities shall not exceed $1000.00 in a State Fiscal Year.

b. Support for pest infestation abatement shall not exceed $2000.00 in a State Fiscal Year;

i. Supports for pest infestation abatement shall not cover more than one infestation event in a State Fiscal Year; and

ii. Multiple treatments per event may be authorized, if determined necessary by a licensed pest abatement professional.

iii. Emergency food support shall not exceed $400.00 in a State Fiscal Year.

8.501.4.C Supporting Independence in the Community.

1. State-SLS may be utilized to provide an individual found eligible for or enrolled in an HCBS Medicaid waiver, with a one-time payment or acquisition of needed household items, in the event the MemberClient is moving into a residence as defined in Section 8.500.93.A.(7).

a. State-SLS funds may be utilized for payment or acquisition of

i. initial housing costs including but not limited to a one-time initial set up for pantry items and/or kitchen supplies and/or furniture purchase.

b. Individuals enrolled in the HCBS-DD waiver residing in an Alternative Care Facility (ACF), Group Residential Supports and Services (GRSS) or Individual Residential

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Supports and Services - Host Home (IRSS-HH) setting are not eligible for this Support.

2. State-SLS funds may support someone to have greater independence when they are moving into their own home, by paying for housing application fee.

3. The CCB shall maintain receipts or paid invoices for purchases authorized in this section. Receipts or paid invoices must contain at a minimum, the following information: business name, item(s) purchased, item(s) cost, date paid, and description of items purchased. Documentation must be made available to the Department upon request. All items must be purchased from an established retailer that has a valid business license.

4. Service limitations

a. The one-time furniture purchase shall not exceed $300.00.

b. The one-time initial pantry set up shall not to exceed $100.00.

c. The one-time purchase of kitchen supplies shall not to exceed $200.00.

d. The payment of housing application fees are limited to five (5) in a State Fiscal Year.

8.501.4.D On-going State-SLS Support.

1. State-SLS funds may be authorized by the CCB for individuals who have been determined to meet the DD Determination requirements, but do not meet the requirements to be enrolled in HCBS-SLS Waiver section 8.500.93.

a. An eligible MemberClient may be authorized to receive any service set forth in the HCBS-SLS waiver regulation at section 8.500.90.

b. Service limitation and service rules found in the HCBS-SLS waiver regulation at section 8.500.90 applies to the State SLS program.

c. A Program Approved Service Agency (PASA) is authorized to provide State-SLS services; and

2. When an individual is enrolled in an HCBS waiver, other than the HCBS-DD or HCBS-SLS waiver and needed Supports and Services not provided by that waiver, the CCB may authorize State-SLS funds.

a. A comparable service must not be available in the enrolled waiver.

b. State-SLS funds may not be utilized for Home Accessible Adaptation, or Vehicle Modification.

c. Only a PASA shall provide these services.

3. Service Limitation

a. Total authorization limit for the plan year shall be determined by the Departments and be communicated annually on the State-SLS Program rate schedule.

8.501.4.E State-SLS Individual Support Plan.

1. State-SLS MemberClients are required to have a State-SLS Individual Support Plan that is signed and authorized by the CCB Case Manager and the MemberClient, or their Guardian.

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2. The State-SLS Individual Support Plan shall be developed through an in-person face to face meeting that includes at least, the individual seeking services and the CCB Case Manager. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or MemberClient (e.g. natural disaster, pandemic, etc.

3. If a MemberClient seeks additional supports or alleges a change in need, the State-SLS Individual Support Plan shall be reviewed and updated by the CCB Case Manager prior to any change in authorized services and supports.

4. The State-SLS Individual Support Plan shall be effective for no more than one year and reviewed at least every 6 months, in a face-to-face meeting with the MemberClient or on a more frequent basis if a change in need occurs. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or MemberClient (e.g. natural disaster, pandemic, etc.

   a. Any changes to the provision of the services and supports identified in the State-SLS Individual Support Plan are subject to available funds within the designated service area.

   b. Any decision to modify, reduce or deny services and supports set forth in the State-SLS Individual Support Plan, without the MemberClient's consent is subject to the Dispute Resolution Process found in section 8.605.2.

5. The State-SLS Individual Support Plan and all supporting documentation will be maintained by the case manager and will be made available to the Department upon request.

6. The State-SLS Individual Support Plan shall include the following;

   a. The Supports and Services authorized, the MemberClient's identified needs and how the Supports and Service will address the needs.

   b. The scope, frequency, and duration of each service.

   c. Documentation demonstrating if other public or community resources have been utilized and why State-SLS funds are being utilized instead of or in combination with other resources.

   d. Total cost of the supports being authorized.

   e. Information to support authorization of services under Supports for Individuals Experiencing Temporary Hardships, including:

      i. A description of the hardship.

      ii. The reason for the hardship.

      iii. The length of time the support will be authorized, including the date of the onset of the hardship and the date it is expected to end.

      iv. Total amount needed to support the individual and what other community resources are contributing.

      v. A plan to reasonably ensure the hardship is temporary.

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vi. A plan to reasonably ensure that dependence on State-SLS funds will be temporary.

vii. The dates of when the long-term solution will be in place and when the temporary hardship is expected to end.

viii. Documentation demonstrating how utilizing State-SLS funds will lead to the MemberClient gaining more independence in the community or maintaining their independence in the community.

f. Additional Information required for authorization of services for the purpose of Supporting Independence in the Community:

i. Total amount needed to support the individual and what other community resources are contributing.

g. Additional Information to be included for authorization of services On-going State - SLS Supports;

i. Documentation demonstrating why the individual enrolled in State-SLS is not eligible or enrolled in a HCBS Medicaid waiver or documentation showing which HCBS waiver the individual is enrolled in; and

ii. Documentation demonstrating how authorized services are not duplicative or comparable to others the individual is eligible for or has access to.

8.501.5 Case Management Services

8.502.5.A Administration

1. CMAs shall comply with all requirements set forth in section 8.607.1.

8.501.5.B Case Management Duties:

1. The case manager shall coordinate, authorize and monitor services based on the approved State-SLS Individual Support Plan.

a. The case manager shall have, based on the MemberClient's preference, a face to face or telephone contact once per quarter with the MemberClient.

2. The CCB Case Manager shall assist MemberClients to gain access to other resources for which they are eligible and to ensure MemberClients secure long-term support as efficiently as possible.

3. The CCB Case Manager shall provide all State-SLS documentation upon the request from the Department.

4. Referrals to the State-SLS program shall be made through the CCB in the geographic catchment area the MemberClient or Applicant resides in.

8.501.6 Transferring Services Between Community Centered Boards:

1. When an individual enrolled in, or on the waiting list for, the State-SLS program moves to another CCB's catchment area, and wishes to transfer their State-SLS, the following procedure shall be followed:

a. The originating CCB, will contact the receiving CCB to inform them of the individual's desire to transfer.

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b. The originating CCB will send the State-SLS Individual Support Plan to the receiving CCB, where the receiving CCB will determine if appropriate State-SLS funding is available or if the individual will need to be placed on a waiting list. The receiving CCB's decision of service availability will be communicated in the following way:

i. The receiving CCB will notify the individual seeking transfer of its decision by the individual's preferred method, no later than ten (10) business days from the date of the request; and

ii. The receiving CCB will notify the originating CCB of its decision by U.S. Mail, phone call or email of its decision no later than ten (10) business days from the date of the request.

c. The decision shall clearly state the outcome of the decision including:

i. The basis of the decision; and

ii. The contact information of the assigned Case Manager or waiting list manager.

d. The originating CCB shall contact the individual requesting the transfer no more than 5 days from the date the decision was received to:

i. Ensure the individual understands the decision; and

ii. Support the individual in making a final decision about the transfer.

e. If the transfer is approved, there shall be a transfer meeting in-person when possible, or by phone if geographic location or time does not permit, within in fifteen (15) business days of when the notification of service determination is sent out by the receiving CCB. The transfer meeting must include but is not limited to the transferring individual and the receiving case manager. Any additional attendees must be approved by the transferring individual.

f. The receiving CCB must ensure that:

i. the transferring individual meets his or her primary contact of the receiving CCB.

ii. The individual is informed of the date when Services and Supports will be transferred, when Services and Supports will be available, and the length of time the Supports and Services will be available.

g. The receiving CCB case manager shall have an in-person face to face meeting with the MemberClient to review and update the State-SLS Individual Support Plan, prior to the Supports and Services being authorized. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or MemberClient (e.g. natural disaster, pandemic, etc.).

8.501.7 WAITING LIST PROTOCOL.

1. Persons determined eligible to receive services under the State SLS program, shall be eligible for placement on a waiting list for services when state funding is unavailable.

2. Waiting lists for persons eligible for the State SLS program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Operating Agency's procedures.

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3. Persons determined eligible shall be placed on the waiting list for services in the Community Centered Board service area of residency.

a. The date used to establish a person's placement on a waiting list shall be:

i. The date on which an individual is determined eligible for the State SLS program through the DD Determination and the identification of need.

4. As funding becomes available in the State SLS program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list.

5. Individuals with no other State or Medicaid funded services or supports will be given priority for enrollment including individuals who lose Medicaid eligibility and lose Medicaid Waiver services.

6. Exceptions to these requirements shall be limited to:

a. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered, and the emergency cannot be resolved in another way. Emergencies are defined as follows:

i. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; or whose primary residence during the night is a public or private facility that provides temporary living accommodations; or any other unstable or non-permanent situation; or is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

ii. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

iii. Danger to Others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

iv. Danger to Self: a person's medical, psychiatric or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

v. Loss or Incapacitation of Primary Caregiver: a person's primary caregiver is no longer in the person's primary residence to provide care; or the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or the primary caregiver is age 65 years or older and continuing to provide care poses an imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.

7. Documentation demonstrating how the individual meets the emergency criteria shall be kept on file at the CCB and made available to the Department upon request.

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~~8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (HCBS-CES)~~

~~8.503 DEFINITIONS~~

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~~A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, transferring, and needing supervision to support behavior, medical needs and memory cognition.~~

~~B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-CES waiver or a HCBS waiver service.~~

~~C. APPLICANT means as defined in Section 8.390.1.~~

~~D. AUTHORIZED REPRESENTATIVE means an individual designated by a MemberClient, or by the parent or guardian of the MemberClient receiving services, if appropriate, to assist the MemberClient receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.~~

~~E. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the Department.~~

~~F. MEMBERCLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-based Services (HCBS).~~

~~G. MEMBERCLIENT REPRESENTATIVE means a person who is designated by the MemberClient to act on the MemberClient's behalf. A MemberClient representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the MemberClient to speak for or act on the MemberClient's behalf.~~

~~H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.~~

~~I. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-based Services, and Medicaid State Plan benefits including long-term home health services and targeted case management.~~

~~J. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the MemberClient.~~

~~K. CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.~~

~~L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single state Medicaid agency.~~

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~~M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.~~

~~N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.~~

~~O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.~~

~~P. FAMILY means a relationship as it pertains to the Member~~Client and is defined as:

~~A mother, father, brother, sister,~~

~~Extended blood relatives such as grandparent, aunt, uncle, cousin,~~

~~An adoptive parent,~~

~~One or more individuals to whom legal custody of a person with a developmental disability has been given by a court,~~

~~A spouse or,~~

~~The Member~~Client's child.

~~Q. FISCAL MANAGEMENT SERVICE (FMS) means the entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual Member~~Client allocations for CDASS.

~~R. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.~~

~~S. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.~~

~~T. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Member~~Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

~~U. INSTITUTION means a hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the state plan.~~

~~V. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately operated facility that provides health and habilitation services to a Member~~Client with developmental disabilities or related conditions.

~~W. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Member~~Client's spouse

~~X. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Member~~Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

~~Y. LEVEL OF CARE SCREEN means as defined in Section 8.391.1.~~

~~Z. LICENSED MEDICAL PROFESSIONAL means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is~~

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limited to those who possess the following medical licenses: physician, physician assistant and nurse governed by the Colorado Medical License Act and the Colorado Nurse Practice Act.

AA. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

BB. MEDICAID ELIGIBLE means the Applicant or MemberClient meets the criteria for Medicaid benefits based on the Applicant's financial determination and disability determination when applicable.

CC. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

DD. MEDICATION ADMINISTRATION means assisting a MemberClient in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

EE. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in the MemberClient's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

FF. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in Home and Community Services for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS- Children's Extensive Supports (HBCS-CES) waivers.

GG. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

HH. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

JJ. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 et seq., that has received program approval to provide HCBS-CES waiver services.

KK. RELATIVE means a person related to the MemberClient by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the MemberClient received services according to the PCSP and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

MM. SUPPORT is any task performed for the MemberClient where learning is secondary or incidental to the task itself or an adaptation is provided.

NN. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program

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~~(CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; Assessment and periodic Reassessment, development and periodic revision of a PCSP, referral and related activities, and monitoring.~~

~~OO. THIRD PARTY RESOURCES means services and supports that a MemberClient may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.~~

~~PP. UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the Department to review the HCBS-CES waiver applications for determination of eligibility based on the additional targeting criteria.~~

~~QQ. WAIVER SERVICE means optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.~~

~~8.503.10 HCBS-CES WAIVER ADMINISTRATION~~

~~A. This section hereby incorporates the terms and provisions of the federally approved Home and Community-based Services-Children's Extensive Support (HCBS-CES) waiver CO.4180.R03.00. To the extent that the terms of that federally approved waiver are inconsistent with the provisions of this section, the waiver will control~~

~~B. HCBS-CES waiver for MemberClients ages birth through seventeen years of age with Developmental Delays or disabilities is administered through the designated Operating Agency.~~

~~C. HCBS-CES waiver services shall be provided in accordance with the federally approved HCBS-CES waiver document and these rules and regulations.~~

~~D. HCBS-CES waiver services are available only to address needs identified in the Functional Needs Assessment and authorized in the Service Plan and when the service or Support is not available through the Medicaid State Plan, EPSDT, Natural Supports, or third-party payment sources.~~

~~E. HCBS-CES waiver:~~

~~1. Shall not constitute an entitlement to services from either the Department or its agents;~~

~~2. Shall be subject to annual appropriations by the Colorado General Assembly;~~

~~3. Shall limit the utilization of the HCBS-CES waiver based on the federally approved capacity, Cost Containment, the maximum costs and the total appropriations; and,~~

~~4. May limit enrollment when utilization of the HCBS-CES waiver program is projected to exceed the spending authority.~~

~~8.503.20 GENERAL PROVISIONS~~

~~A. The following provisions apply to the HCBS – CES waiver:~~

~~1. HCBS-CES waiver services are provided as an alternative to ICF-IID services for an eligible MemberClient to assist the Family to Support the MemberClient in the home and community.~~

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2. HCBS-CES waiver is waived from the requirements of Section 1902(a) (10) (b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the state of Colorado.

3. A MemberClient enrolled in the HCBS-CES waiver shall be eligible for all other Medicaid services for which the MemberClient qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-CES waiver. Services received through the HCBS-CES waiver may not duplicate services available through the Medicaid State Plan.

8.503.30 MEMBERCLIENT ELIGIBILITY

A. To be eligible for the HCBS-CES waiver, an individual shall meet the target population criteria as follows:

1. Is unmarried and less than eighteen years of age,

2. Be determined to have a Developmental Disability which includes Developmental Delay if under five (5) years of age,

3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and Cost Containment limits of the HCBS-CES waiver,

4. Meet ICF-IID Level of Care as determined by the LOC Screen.

5. Meet the Medicaid financial determination for Long-term Care (LTC) eligibility as specified at Section 8.100 *et seq*. and,

6. Reside in an eligible HCBS-CES waiver setting as defined as the following:

a. With biological, adoptive parent(s), or legal Guardian,

b. In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement:

i. The case manager will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or Supports requested during the time the MemberClient is not residing in the Family home. The case manager will submit the transition plan to the Department for approval prior to the start of services.

7. Be determined to meet the Federal Social Security Administration's definition of disability,

8. Be determined by the Department or its agent to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:

a. The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically Age Appropriate and due to one or more of the following conditions:

i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life-threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six (6) months,

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ii. A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six (6) months, or

iii. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

b. In the instance of an annual Reassessment, the Reassessment must demonstrate in the absence of the existing interventions or preventions provided through Medicaid that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criterion listed above.

B. The MemberClient shall maintain eligibility by meeting the HCBS-CES waiver eligibility as set forth in Section 8.503 and the following:

1. Receives at least one (1) HCBS-CES waiver service each calendar month,

2. Is not simultaneously enrolled in any other HCBS waiver, and

3. Is not residing in a hospital, nursing facility, ICF-IID, other Institution or correctional facility.

8.503.40 HCBS-CES WAIVER SERVICES

A. The following services are available through the HCBS-CES waiver within the specific limitations as set forth in the federally approved HCBS-CES waiver:

1. Adaptive therapeutic recreational equipment and fees are services which assist a MemberClient to recreate within the MemberClient's community. These services include recreational equipment that is adapted specific to the MemberClient's disability and not those items that a typical age peer would commonly need as a recreation item.

a. The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.

b. Adaptive therapeutic recreational equipment may include adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a MemberClient with a Developmental Disability.

c. A pass for admission to recreation centers for the MemberClient only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.

d. Adaptive therapeutic recreation fees include those for water safety training.

e. The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. Entrance fees for zoos,

ii. Museums,

iii. Butterfly pavilion,

iv. Movie, theater, concerts,

v. Professional and minor league sporting events,

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~~vi. Outdoors play structures,~~

~~vii. Batteries for recreational items; and,~~

~~viii. Passes for Family admission to recreation centers.~~

~~f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per Service Plan year.~~

~~2. Assistive technology includes services, Supports or devices that assist a MemberClient to increase maintain or improve functional capabilities. This may include assisting the MemberClient in the selection, acquisition, or use of an assistive technology device and includes:~~

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

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

~~c. Training or technical assistance for the MemberClient, or where appropriate, the Family members, Guardians, caregivers, advocates, or authorized representatives of the MemberClient,~~

~~d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-CES waiver, and~~

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

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

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

~~h. When the expected cost is to exceed two thousand five hundred (2,500) dollars per device three estimates shall be obtained and maintained in the case record.~~

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

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

~~i. Purchase, training or maintenance of service animals,~~

~~ii. Computers,~~

~~iii. In home installed video monitoring equipment,~~

~~iv. Medication reminders,~~

~~v. Hearing aids,~~

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

vii. Training, or adaptation directly related to a school or home educational goal or curriculum; or

viii. Items considered as typical toys for children.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the MemberClient or that enable the MemberClient to function with greater independence in the home or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Department's procedures and the Department shall respond to exception requests within thirty (30) days of receipt.

3. Community connector services are intended to provide assistance to the MemberClient to enable the MemberClient to integrate into the MemberClient's residential community and access naturally occurring resources. Community connector services shall:

a. Support the abilities and skills necessary to enable the MemberClient to access typical activities and functions of community life such as those chosen by the general population.

b. Utilize the community as a learning environment to assist the MemberClient to build relationships and Natural Supports in the MemberClient's residential community.

c. Be provided to a single MemberClient in a variety of settings in which MemberClients interact with individuals without disabilities, and

d. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.

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

a. Hippotherapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Hippotherapy can be reimbursed only when:

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

ii. The intervention is related to an identified medical or behavioral need; and

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

b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

i. Equine therapy,

ii. Therapeutic riding; and,

iii. Experimental treatments or therapies.

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~~8.503.40.A.5. HOME ACCESSIBILITY ADAPTATIONS~~

~~8.503.40.A.5.a DEFINITIONS~~

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

~~Case Manager means a person who provides case management services and meets all regulatory requirements for case managers.~~

~~The Division of Housing (DOH) is a division within the Colorado Department of Local Affairs that is responsible for approving Home Accessibility Adaptation PARs, oversight on the quality of Home Accessibility Adaptation projects, and inspecting Home Accessibility Adaptation projects, as described in these regulations~~

~~2. DOH oversight is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, all oversight functions shall be performed by the Department unless specifically allowed by the Participant or their guardian to be performed by DOH.~~

~~Home Accessibility Adaptations means the most cost-effective physical modifications, adaptations, or improvements in a Participant's existing home setting which, based on the Participant's medical condition or disability:~~

~~1. Are necessary to ensure the health and safety of the Participant, or~~

~~2. Enable the Participant to function with greater independence in the home, or~~

~~3. Prevent institutionalization or support the deinstitutionalization of the Participant.~~

~~Home Accessibility Adaptation Provider means a provider agency that meets all the standards for Home Accessibility Adaptation described in Section 8.503.A.5.e and is an enrolled Medicaid provider.~~

~~Person-Centered Planning means Home Accessibility Adaptations that are agreed upon through a process that is driven by the Participant and can include people chosen by the Participant, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations; and where the Participant is provided necessary information, support, and choice Participant to ensure that the Participant directs the process to the maximum extent possible.~~

~~8.503.40.A.5.b INCLUSIONS~~

~~8.503.40.A.5.b.i. Home Accessibility Adaptations may include, but are not limited to, the following:~~

~~a) Installing or building ramps;~~

~~b) Installing grab-bars or other Durable Medical Equipment (DME) if such installation cannot be performed by a DME supplier;~~

~~c) Widening or modification of doorways;~~

~~d). Modifying a of bathroom facility for the purposes of accessibility, health and safety, and independence in Activities of Daily Living;~~

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~~e) Modifying a kitchen for purposes of accessibility, health and safety, and independence in Activities of Daily Living;~~

~~d) Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies;~~

~~g) Installing stair lifts or vertical platform lifts;~~

~~h) Modifying an existing second exit or egress window to lead to an area of rescue for emergency purposes;~~

~~i) The modification of a second exit or egress window must be approved by the Department or DOH at any funding level as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the Participant.~~

~~i) Safety enhancing supports such as basic fences, strengthened windows, and door and window alerts.~~

~~8. 503.40.A.5.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of Section 8.503.40.A.5.~~

~~8. 503.40.A.5.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.~~

~~8. 503.40.A.5.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.~~

~~8. 503.40.A.5.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.~~

~~a) Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the Participant, or enable the Participant to function with greater independence in the home, if:~~

~~i) The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and~~

~~ii) Either:~~

~~1. There is an immediate risk to the Participant's health or safety, or~~

~~2. There has been a significant change in the Participant's needs since a previous Home Accessibility Adaptation.~~

~~b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule section 8.503.A.5.~~

~~8. 503.40.A.5.c EXCEPTIONS AND RESTRICTIONS~~

~~8. 503.40.A.5.c.i Home Accessibility Adaptations must be a direct benefit to the Participant and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.~~

~~8. 503.40.A.5.c.ii Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, are prohibited.~~

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~~8. 503.40.A.5.c.iii Adaptations, improvements, or modifications as a part of new construction costs are prohibited.~~

~~a) Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.~~

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

~~i) improve entrance or egress to a residence; or,~~

~~ii) configure a bathroom to accommodate a wheelchair.~~

~~c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department procedures.~~

~~8. 503.40.A.5.c.iv The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.~~

~~8.503.40.A.5.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.~~

~~8.503.40.A.5.c.vi. Upgrades beyond what is the most cost-effective means of meeting the Participant's identified need, including, but not limited to, items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.~~

~~8.503.40.A.5.c.vii. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:~~

~~a) Roof repair,~~

~~b) Central air conditioning,~~

~~c) Air duct cleaning,~~

~~d) Whole house humidifiers,~~

~~e) Whole house air purifiers,~~

~~f) Installation and repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,~~

~~g) Monthly or ongoing home security monitoring fees,~~

~~h) Home furnishings of any type,~~

~~i) HOA fees.~~

~~8.503.40.A.5.c.viii. Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.~~

~~8.503.40.A.5.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other~~

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federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.503.40.A.5.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the 2018 Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to Sect24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8. 503.40.A.5.d CASE MANAGEMENT AGENCY RESPONSIBILITIES

8. 503.40.A.5.d.i. The Case Manager shall consider alternative funding sources to complete the Home Accessibility Adaptation. These alternatives considered and the reason they are not available shall be documented in the case record.

1) The Case Manager must confirm that the Participant is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding. Case Managers may request confirmation of a property owner's obligations through DOH.

8. 503.40.A.5.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval and confirmation of Home Accessibility Adaptation fund availability.

8. 503.40.A.5.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization Request form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5. Home Accessibility Adaptations submitted with improper documentation will not be approved.

2) The Case Manager and CMA are responsible for retaining and tracking all documentation related to a Participant's Home Accessibility Adaptation funding use and communicating that information to the Participant and Home Accessibility Adaptation providers. The Case Manager may request confirmation of a Participant's Home Accessibility Adaptation fund use from the Department or DOH.

3) The Case Manager shall discuss any potential plans to move to a different residence with the Participant or their guardian and advise them on the most prudent utilization of available funds.

8. 503.40.A.5.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1) An occupational or physical therapist (OT/PT) shall assess the Participant's needs and the therapeutic value of the requested Home Accessibility Adaptation. When an OT/PT with experience in Home Accessibility Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Accessibility

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~~Adaptation would contribute to a Participant's ability to remain in or return to his/her home, and how the Home Accessibility Adaptation would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.~~

~~a) The evaluation must be performed in the home to be modified. If the Participant is unable to access the home to be modified without the modification, the OT/PT must evaluate the Participant and home separately and document why the Participant was not able to be evaluated in the home.~~

~~2) The evaluation may be provided by a home health agency or other qualified and approved OT/PT through the Medicaid Home Health benefit.~~

~~a) A Case Manager may initiate the OT/PT evaluation process before the Participant has been approved for waiver services, as long as the Participant is Medicaid eligible.~~

~~b) A Case Manager may initiate the OT/PT evaluation process before the Participant physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.~~

~~c) OT/PT evaluations performed by non-enrolled Medicaid providers may be accepted when an enrolled Medicaid provider is not available. A Case Manager must document the reason why an enrolled Medicaid provider is not available.~~

~~3) The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Participant's needs. The Case Manager shall document these alternatives and why they did not meet the Participant's needs in the Participant's case file.~~

~~8. 503.40.A.5.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:~~

~~1) The Case Manager shall assist the Participant in soliciting bids from at least two Home Accessibility Adaptation Providers for Home Accessibility Adaptations estimated to cost $2,500 or more.~~

~~2) The Case Manager must verify that the provider is an enrolled Home Accessibility Adaptation Provider for Home Accessibility Adaptations.~~

~~3) The bids for Home Accessibility Adaptations at all funding levels shall include a breakdown of the costs of the project and the following:~~

~~a) Description of the work to be completed.~~

~~b) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.~~

~~c) Estimate for building permits, if needed,~~

~~d) Estimated timeline for completing the project,~~

~~e) Name, address and telephone number of the Home Accessibility Adaptation Provider,~~

~~f) Signature, physical or digital, of the Home Accessibility Adaptation Provider,~~

~~g) Signature or other indication of approval, such as email approval, of the Participant or their guardian, that indicates all aspects of the bid have been reviewed with them,~~

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~~h) Signature, physical or digital, of the homeowner or property manager if the home is not owned by the Participant or their guardian.~~

~~4) Home Accessibility Adaptation Providers have a maximum of thirty (30) days to submit a bid for the Home Accessibility Adaptation project after the Case Manager has solicited the bid.~~

~~a) If the Case Manager has made three attempts to obtain a bid from a Home Accessibility Adaptation Provider and the provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.~~

~~5) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.503.40.A.5 and the recommendations of the OT/PT evaluation.~~

~~a) If a Participant or home owner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.~~

~~6) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.503.40.A.5.~~

~~8. 503.40.A.5.d.vi. If a property to be modified is not owned by the Participant or their guardian, the Case Manager shall obtain physical or digital, signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein.~~

~~1) Written consent of the home owner or property manager is required for all projects that involve permanent installation within the Participant's residence or installation or modification of any equipment in a common or exterior area.~~

~~2) The authorization shall include confirmation that the home owner or property manager agrees that if the Participant vacates the property, the Participant may choose to either leave the modification in place or remove the modification, that the home owner or property manager may not hold any party responsible for removing all or part of a Home Accessibility Adaptation project, and that if the Participant chooses to remove the modification, the property must be left in equivalent or better than its pre-modified condition.~~

~~8. 503.40.A.5.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation, the Department may hold the CMA financially liable for the increased cost.~~

~~8. 503.40.A.5.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR.~~

~~8. 503.40.A.5.e PROVIDER RESPONSIBILITIES~~

~~8. 503.40.A.5.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in Section 8.500.98.~~

~~8. 503.40.A.5.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the Home Accessibility Adaptation services will be performed, if required by that city or county.~~

~~8. 503.40.A.5.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.~~

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~~1) If any changes to the approved scope of work are made without DOH or Department authorization, the cost of those changes will not be reimbursed.~~

~~2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.~~

~~8. 503.40.A.5.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's expense.~~

~~1) The Provider shall give the Participant or their guardian all manufacturer's or seller's warranties on completion of work.~~

~~8. 503.40.A.5.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications developed by the DOH, which can be found on the Department website, and with local, and state building codes.~~

~~8. 503.40.A.5.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Accessibility Adaptation projects may be inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. Participants must provide access for inspections.~~

~~1) DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion for sampled projects, or receipt of a Participant's reasonable request.~~

~~2) DOH shall produce a written inspection report within the time frame agreed upon in the Home Accessibility Adaptations work plan that notes the Participant's specific complaints. The inspection report shall be sent to the Participant, Case Manager, and provider.~~

~~3) Home Accessibility Adaptation providers must repair or correct any noted deficiencies within twenty (20) days or the time required by the inspection, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.~~

~~8. 503.40.A.5.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis for non-payment or recovery of payment by the Department.~~

~~1) Volunteer work on a Home Accessibility Adaptation project approved by the Department shall be completed under the supervision of the Home Accessibility Adaptation Provider as stated on the bid.~~

~~a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5.~~

~~b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5.~~

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~~8. 503.40.A.5.f REIMBURSEMENT~~

~~8. 503.40.A.5.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments.~~

~~8. 503.40.A.5.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.~~

~~8. 503.40.A.5.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation to DOH:~~

~~1) Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;~~

~~2) Required permits;~~

~~3) One year written warranty on materials and labor; and~~

~~4) Documentation in the Participant's file that the Home Accessibility Adaptation has been completed satisfactorily through:~~

~~a) Receipt of the inspection report approving work from the state, county, or local building, plumbing, or electrical inspector;~~

~~b) Approval by the Participant, guardian, representative, or other designee;~~

~~c) Approval by the home owner or property manager;~~

~~d) A final on-site inspection report by DOH or its designated inspector; or~~

~~e) DOH acceptance of photographs taken both before and after the Home Accessibility Adaptation.~~

~~8. 503.40.A.5.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.~~

~~8. 503.40.A.5.f.v. The Home Accessibility Adaptation Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.~~

~~1) All required repairs noted on inspections shall be completed before the Home Accessibility Adaptation Provider submits a final claim for reimbursement.~~

~~2) If a Home Accessibility Adaptation Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the provider during an inspection. The provider shall only be reimbursed for the value of the work completed satisfactorily.~~

~~a) A Home Accessibility Adaptation Provider may request DOH perform one (1) reconsideration of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the provider's expense.~~

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8. 503.40.A.5.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.

1) Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 7 day deadline and be supported by documentation, including Participant notification.

2) The Home Accessibility Adaptation reimbursement reduced pursuant to this subsection shall be considered part of the Participant's remaining funds.

8. 503.40.A.5.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

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

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

i. This assistance may take the form of hands-on assistance by actually performing a task for the MemberClient or cueing to prompt the MemberClient to perform a task.

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

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

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

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

1). When such Support is incidental to the habilitative services being provided,

2). To increase independence of the MemberClient,

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

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

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

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~~a. Massage therapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Massage therapy is reimbursed only when:~~

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

~~ii. The intervention is related to an identified medical or behavioral need; and~~

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

~~b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:~~

~~i. Acupuncture,~~

~~ii. Chiropractic care, and,~~

~~iii. Experimental treatments or therapies.~~

~~8. Movement therapy includes the use of music therapy and/ or dance therapy as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.~~

~~a. Movement therapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need and Movement therapy can be reimbursed only when:~~

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

~~ii. The intervention is related to an identified medical or behavioral need; and,~~

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

~~b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:~~

~~i. Fitness training (personal trainer),~~

~~ii. Warm water therapy,~~

~~iii. Experimental treatments or therapies, and~~

~~iv. Yoga.~~

~~9. Parent education provides unique opportunities for parents or other care givers to learn how to Support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. Parent education includes:~~

~~a. Consultation and direct service costs for training parents and other caregivers in techniques to assist in caring for the Member~~Client's needs, ~~including sign language training,~~

~~b. Special resource materials,~~

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~~c. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the MemberClient's disability, and~~

~~d. Cost of membership to parent Support or information organizations and publications designed for parents of children with disabilities.~~

~~e. The maximum service limit for parent education is one thousand (1,000) units per Service Plan year.~~

~~f. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:~~

~~i. Transportation,~~

~~ii. Lodging,~~

~~iii. Food, and~~

~~iv. Membership to any political organizations or any organization involved in lobby activities.~~

~~10. Respite is provided to MemberClients on a short-term basis, because of the absence or need for relief of the primary caregivers of the MemberClient.~~

~~a. Respite may be provided:~~

~~i. In the MemberClient's home or a private residence,~~

~~ii. The private residence of a respite care provider, or~~

~~iii. In the community.~~

~~b. Respite is to be provided in an Age Appropriate manner.~~

~~i. A MemberClient eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children.~~

~~c. When the cost of care during the time the parents works is more for an eligible MemberClient, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care.~~

~~d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible MemberClient when supervision is needed so the primary caretaker can take the MemberClient to receive a state plan benefit or a HCBS-CES waiver service.~~

~~e. Respite shall be provided according to an individual or group rates as defined below:~~

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

~~ii. Individual day: the MemberClient receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty-four (24)-hour period. A full day is ten (10) hours or greater within a twenty-four (24)- hour period.~~

~~iii. Overnight group: the MemberClient receives respite in a setting which is defined as a facility that offers twenty-four (24)-hour supervision through supervised overnight group~~

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accommodations. The total cost of overnight group within a twenty-four (24)-hour period shall not exceed the respite daily rate.

iv. Group: the MemberClient receives care along with other individuals, who may or may not have a disability. The total cost of group within a twenty-four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:

1) Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling.

f. Federal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to Section 8.602 by the state that is not a private residence.

g. The total amount of respite provided in one Service Plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The Department may approve a higher amount based on a need due to the MemberClient's age, disability or unique Family circumstances.

h. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or other services not covered by the HCBS-CES waiver.

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

j. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a MemberClient. Therefore, additional respite units beyond the service limit will not be approved for MemberClients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.

11. Specialized medical equipment and supplies include devices, controls, or appliances that are required due to the MemberClient's disability and that enable the MemberClient to increase the MemberClient's ability to perform Activities of Daily Living or to safely remain in the home and community. Specialized Medical Equipment and Supplies include:

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

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

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

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

i. Items that are not of direct medical or remedial benefit to the MemberClient, vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items and wipes for any purpose other than incontinence.

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

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

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b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include:

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

ii. Purchase or lease of a vehicle, and

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

c. The total cost of Home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the MemberClient, to enable the MemberClient to function with greater independence in the home, or to decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure Cost Effectiveness, prudent purchases and no unnecessary duplication.

13. Youth Day

a. Youth day service is the care and supervision of MemberClients ages 12 through 17 while the primary caregiver works, volunteers, or seeks employment.

b. Youth day service may be provided in the residence of the MemberClient, youth day service provider, or in the community.

c. Youth day service shall be provided according to an individual or group rate as defined below:

i. Individual: The MemberClient receives youth day services with a staff ratio of 1:1, billed at a 15-minute unit. There are no other youth in the setting also receiving youth day service, respite or third-party supervision.

ii. Group: The MemberClient receives supervision in a group setting with other individuals who may or may not have a disability. Reimbursement is limited to the MemberClient.

d. Limitations:

i. This service is limited to MemberClients ages 12 through 17.

ii. This service may not substitute for or supplant special education and related services included in a MemberClient's Individualized Education Plan (IEP) developed under Part B of the Individuals with Disabilities Education Act, 20 U.S.cC. § 1400 (2011). This includes after school care provided through any education system and funded through any education system for any student.

iii. This service may not be used to cover any portion of the cost of camp.

iv. This service is limited to ten (10) hours per calendar day.

8.503.50 SERVICE PLAN.

The case management agency shall complete a service plan for each MemberClient enrolled in the HCBS-CES waiver in accordance with Section 8.519.11.B.2.

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~~8.503.60 WAITING LIST PROTOCOL~~

~~A. When the HCBS-CES waiver reaches capacity for enrollment, a MemberClient determined eligible for HCBS-CES waiver benefits shall be placed on a statewide waiting list in accordance with these rules and the Department's procedures.~~

~~1. The Community Centered Board shall determine if an Applicant has Developmental Delay if under age five (5), or Developmental Disability if over age five (5) , prior to submitting the HCBS-CES waiver application to the Department or its agent. Only a MemberClient who is determined to have a Developmental Delay or Developmental Disability may apply for HCBS-CES waiver.~~

~~2. In the event a MemberClient who has been determined to have a Developmental Delay is placed on the wait list prior to age five (5), and that MemberClient turns five (5) while on the HCBS-CES waiver wait list, a determination of Developmental Disability must be completed in order for the MemberClient to remain on the wait list.~~

~~3. The Case Management Agency shall complete the LOC Screen as defined in Department rules, to determine the MemberClient's Level of Care.~~

~~4. The Case Management Agency shall complete the HCBS-CES waiver application (for use with the ULTC 100.2 only) with the participation of the Family. The completed application and a copy of the LOC Screen that determines the MemberClient meets the ICF-IID Level of Care shall be submitted to the Department or its agent within fourteen (14) calendar days of parent signature.~~

~~5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the Department or its agent.~~

~~6. The Department or its agent shall review the HCBS-CES waiver application. In the event the Department or its agent needs additional information; the Case Management Agency shall respond within two (2) business days of request.~~

~~7. Any MemberClient determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide waiting list in the order in which the Department or its agent received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the MemberClient's appeal rights in accordance with Section 8.057.~~

~~8. The Case Management Agency will create or update the consumer record to reflect the MemberClient is waiting for the HCBS-CES waiver with the waiting list date as determined by the Department or its agent.~~

~~8.503.70 ENROLLMENT~~

~~A. When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.~~

~~1. The Case Management Agency shall complete the HCBS-CES waiver application (with ULTC 100.2 only) and the LOC Screen in the Family home with the participation of the Family. The completed application, as applicable, and a copy of the LOC Screen shall be submitted to the Department or its agent within thirty (30) days of the authorized initial enrollment date.~~

~~a. If it has been less than six (6) months since the review to determine waiting list eligibility by the URC and there has been no change in the MemberClient's condition, the Case Management Agency shall complete the LOC Screen and the parent may submit a letter to the~~

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Case Management Agency in lieu of the HCBS-CES waiver application stating there has been no change.

b. If there has been any change in the MemberClient's condition the Case Management Agency shall complete a LOC Screen and the HCBS-CES waiver application, as applicable, which shall be submitted to the Department or its agent.

2. Services and Supports shall be implemented pursuant to the PCSP within 90 days of the parent or Guardian signature.

3. All continued stay review enrollments shall be completed and submitted to the Department or its agent at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

8.503.80 MEMBERCLIENT RESPONSIBILITIES

A. The parent or legal Guardian of a MemberClient is responsible to assist in the enrollment of the MemberClient and cooperate in the provision of services. Failure to do so shall result in the MemberClient's termination from the HCBS-CES waiver. The parent or legal Guardian shall:

1. Provide accurate information regarding the MemberClient's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions;

2. Cooperate with providers and Case Management Agency requirements for the HCBS-CES waiver enrollment process, Reassessment process and provision of services;

3. Cooperate with the local Department of Human Services in the determination of financial eligibility;

4. Complete the HCBS-CES waiver application with fifteen (15) calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a Reassessment, at least thirty (30) days prior to the end of the current certification period;

5. Complete the PCSP within thirty (30) calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the Department or its agent.

6. Notify the case manager within thirty (30) days after changes:

a. In the MemberClient's Support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF-IID placements;

b. That may affect Medicaid financial eligibility such as prompt report of changes in income or resources;

c. When the MemberClient has not received an HCBS-CES waiver service for one calendar month;

d. In the MemberClient's care needs; and,

e. In the receipt of any HCBS-CES waiver services.

8.503.90 PROVIDER REQUIREMENTS

A. A private for profit or not for profit agency or government agency shall ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver and shall:

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~~1. Conform to all state established standards for the specific services they provide under HCBS-CES waiver,~~

~~2. Maintain program approval and certification from the Department,~~

~~3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in Section 8.130,~~

~~4. Discontinue HCBS-CES waiver services to a MemberClient only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide HCBS-CES waiver services,~~

~~5. Have written policies governing access to duplication and dissemination of information from the MemberClient's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S.,~~

~~6. When applicable, maintain the required licenses and certifications from the Colorado Department of Public Health and Environment, and~~

~~7. Maintain MemberClient records to substantiate claims for reimbursement according to Medicaid standards.~~

~~B. HCBS-CES waiver service providers shall comply with:~~

~~1. All applicable provisions of Article 10 of Title 25.5, C.R.S. and all rules and regulations as set forth in Section 8.600,~~

~~2. All federal and state program reviews or financial audit of HCBS-CES waiver services,~~

~~3. The Department's on-site certification reviews for the purpose of program approval, on-going program monitoring or financial and program audits,~~

~~4. Requests from the County Departments of Human Services to access records of MemberClients and to provide necessary MemberClient information to determine and re-determine Medicaid financial eligibility,~~

~~5. Requests by the Department to collect, review and maintain individual or agency information on the HCBS-CES waiver, and~~

~~6. Requests by the Case Management Agency to monitor service delivery through targeted case management activities.~~

~~8.503.100 TERMINATION OR DENIAL OF HCBS-CES MEDICAID PROVIDER AGREEMENTS~~

~~A. The Department may deny or terminate an HCBS-CES waiver Medicaid provider agreement when:~~

~~1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at Section 8.076.~~

~~2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-CES waiver services.~~

~~3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.~~

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4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior MemberClient notification.

5. The provider fails to comply with requirements for submission of claims under Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with procedures at Section8.076.

8.503.110 ORGANIZED HEALTH CARE DELIVERY SYSTEM

A. The Organized Health Care Delivery System (OHCDS) for HCBS-CES waiver is the Community Centered Board as designated by the Department in accordance with Section 25.5 -10-209, C.R.S..

1. The OHCDS is the Medicaid provider of record for a MemberClient whose services are delivered through the OHCDS.

2. The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS-CES waiver services according to the current federally approved waiver.

3. The OHCDS may contract or employ for delivery of HCBS-CES waiver services.

4. The OCHDS shall:

a. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver,

b. Ensure that services are delivered according to the HCBS-CES waiver definitions and as identified in the MemberClient's Service Plan,

c. Ensure the contractor maintains sufficient documentation to Support the claims submitted, and

d. Monitor the health and safety of HCBS-CES waiver MemberClients receiving services from a subcontractor.

5. The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

a. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

b. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

c. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to MemberClients

d. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and the Department's procedures:

i. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

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e. Collect and maintain the data used to develop provider rates and ensure data includes costs for the services to address the MemberClient's needs, that are allowable activities within the HCBS-CES waiver service definition and that Supports the established rate, and

f. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency and Centers for Medicare and Medicaid Services (CMS).

g. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.503.120 PRIOR AUTHORIZATION REQUESTS

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14.

8.503.130 RETROSPECTIVE REVIEW PROCESS

A. Services provided to a MemberClient are subject to a Retrospective Review by the Department or its agent. This Retrospective Review shall ensure that services:

1. Identified in the Service Plan is based on the MemberClient's identified needs as stated in the Functional Needs Assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a MemberClient are in accordance with the Service Plan, and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-CES waiver.

B. The Case Management Agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department or its agent when areas of non-compliance are identified in the Retrospective Review.

C. The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

D. When the provider has received reimbursement for services and the review by the Department or its agent identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of the provider agreement.

8.503.140 PROVIDER REIMBURSEMENT

A. Providers shall submit claims directly to the Department's fiscal agent through the Medicaid Management Information System (MMIS) or through a qualified billing agent enrolled with the Department's fiscal agent.

1. Provider claims for reimbursement shall be made only when the following conditions are met:

a. Services are provided by a qualified provider as specified in the federally approved HCBS-CES waiver,

b. Services have been prior authorized,

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c. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the MemberClient's Service Plan, and

d. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the Service Plan and in accordance with the service definition.

2. Provider claims for reimbursement shall be subject to review by the Department or its agent. This review may be completed before or after payment has been made to the provider.

3. When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department or its agent.

4. When the provider has received reimbursement for services and the review by the Department or its agent identifies that the service delivered, or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.503.150 MEMBERCLIENT RIGHTS

A. MemberClient rights should be in accordance with Sections 25.5-10-218 through 231, C.R.S.

8.503.160 APPEAL RIGHTS

Case Management Agencies shall meet the requirements set forth at Section 8.519.22

8.503.160.A The CCB shall provide the long-term care notice of action form to the applicant and MemberClient's parent or legal guardian within eleven (11) business days regarding the MemberClient's appeal rights in accordance with Section 8.057 *et seq.* when:

1. The MemberClient or applicant is determined not to have a developmental delay or developmental disability,

2. The MemberClient or applicant is determined eligible or ineligible for Medicaid LTSS,

3. The MemberClient or applicant is determined eligible or ineligible for placement on a waiting list for Medicaid LTSS,

4. An Adverse Action occurs that affects the MemberClient's or applicant's HCBS-CES waiver enrollment status through termination or suspension,

8.503.160.B The CCB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CCB has made a denial or adverse action against a MemberClient or applicant.

8.503.160.C The CCB shall notify the Case Management Agency in the MemberClient's service plan within one (1) business day of the adverse action.

8.503.160.D The CCB shall notify the County Department of Human Services income maintenance technician within one (1) business day of an Adverse Action that affects Medicaid financial eligibility.

8.503.160.E The CCB shall inform the applicant's or MemberClient's parent or legal guardian of an adverse action if the applicant or MemberClient is determined ineligible and the following:

1. The MemberClient or applicant, parent or legal guardian fails to submit the Medicaid financial application for LTC to the financial eligibility site within thirty (30) days of LTC referral,

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2. A MemberClient, parent or legal guardian fails to submit financial information for re-determination for LTC to the financial eligibility site within the required re-determination timeframe,

3. The County Income Maintenance Technician has determined the MemberClient no longer meets financial eligibility criteria as set forth in Section 8.100,

4. The MemberClient cannot be served safely within the cost containment as identified in the HCBS-CES waiver,

5. The MemberClient requires twenty-four (24) hour supports provided through Medicaid state plan,

6. The resulting total cost of services provided to the MemberClient, including Targeted Case Management, home health and HCBS-CES waiver services, exceeds the cost containment as identified in the HCBS-CES waiver,

7. The MemberClient enters an institution for treatment with duration that continues for more than thirty (30) days,

8. The MemberClient is detained or resides in a correctional facility, and

9. The MemberClient enters an institute for mental illness with a duration that continues for more than thirty (30) days.

8.503.170 QUALITY ASSURANCE

A. The monitoring of HCBS-CES waiver services and the health and well-being of service recipients shall be the responsibility of the Department or its agent.

1. The Department or its agent may conduct reviews of each agency providing HCBS-CES waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department. The review will apply rules and standards developed for programs serving MemberClients with developmental disabilities.

2. The provider agency shall maintain or cause to be maintained for six (6) years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-CES waiver or the delivery of services under the HCBS-CES waiver. The Department shall have access to these records at any reasonable time.

3. The Department may deny or terminate the Medicaid provider agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Department within the prescribed period of time.

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~~8.504 HOME AND COMMUNITY BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESS WAIVER~~

~~8.504.05 Legal Basis~~

~~The Home and Community-based Services for Children with Life Limiting Illness program (HCBS-CLLI) in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CLLI program is also authorized under state law at Section 25.5-5-305 C.R.S.~~

~~8.504.1 DEFINITIONS~~

~~A. Assessment shall be as defined at Section 8.390.1.DEFINITIONS.~~

~~B. Bereavement Counseling means counseling provided to the MemberClient and/or family members in order to guide and help them cope with the MemberClient's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the MemberClient and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.~~

~~C. Case Management means as defined in Section 8.390.1 DEFINITIONS.~~

~~D. Continued Stay Review (CSR) means a Reassessment as defined in Section 8.390.1 DEFINITIONS.~~

~~E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital.~~

~~F. Curative Treatment means medical care or active treatment of a medical condition seeking to affect a cure.~~

~~G. Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the MemberClient to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.~~

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

~~I. Level of Care Screen means as defined in Section 8.391.1.~~

~~J. Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood at age 19.~~

~~K. Massage Therapy means the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.~~

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L. Palliative/Supportive Care is a specific program offered by a licensed health care facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care is specialized medical care for people with life limiting illnesses. This type of care is focused on providing MemberClients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the MemberClient and the family. Palliative care is appropriate at any age (18 and under for this waiver) and at any stage in a life limiting illness and can be provided together with curative treatment. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of this waiver, Palliative Care includes Care Coordination and Pain and Symptom Management.

1. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the MemberClient and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the MemberClient to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a seamless system of care. Care Coordination does not include utilization management, that is review and authorization of service requests, level of care determinations, and waiver enrollment, provided by the case manager at the Single Entry Point.

2. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the MemberClient's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

M. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.

Prior Authorization Request (PAR) means the Department's prescribed form to authorize services.

N. Professional Medical Informa.tion Page (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

O. Respite Care means services provided to an eligible MemberClient who is unable to care for himself/herself on a short-term basis because of the absence or the need for relief of those persons normally providing care. Respite Care may be provided through different levels of care depending upon the needs of the MemberClient. Respite care may be provided in the MemberClient's residence, in the community, or in an approved respite center location.

P. Therapeutic Life Limiting Illness Support means grief/loss or anticipatory grief counseling that assist the MemberClient and family to decrease emotional suffering due to the MemberClient's health status, to decrease feelings of isolation or to cope with the MemberClient's life limiting diagnosis. Support is intended to help the child and family in the disease process. Support is provided to the MemberClient to decrease emotional suffering due to health status and develop coping skills. Support is provided to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the MemberClient, and impending death of a child. Support is provided to the MemberClient and/or family members in order to guide and help them cope with the MemberClient's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Support will include but is not limited

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to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the family with community resources such as funding or transportation.

Q. Utilization Review means approving or denying admission or continued stay in the waiver based on level of care needs, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures or settings.

8.504.2 BENEFITS

8.504.2.A. Home and Community-based Services under the Children with Life Limiting Illness Waiver (HCBS-CLLI) benefits shall be provided within Cost Containment.

8.504.2.B. Therapeutic Life Limiting Illness Support may be provided in individual or group setting.

1. Therapeutic Life Limiting Illness Support shall only be a benefit if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

2. Therapeutic Life Limiting Illness Support is limited to the MemberClient's assessed need up to a maximum of 98 hours per annual certification period.

8.504.2.C. Bereavement Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

1. Bereavement Counseling is limited to the MemberClient's assessed need and is only billable one time.

2. Bereavement Counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

8.504.2.D. Expressive Therapy may be provided in an individual or group setting.

1. Expressive Therapy is limited to the MemberClient's assessed need up to a maximum of 39 hours per annual certification period.

8.504.2.E. Massage Therapy shall be provided in an individual setting.

1. Massage Therapy shall only be used for the treatment of conditions or symptoms related to the MemberClient's illness.

2. Massage Therapy shall be limited to the MemberClient's assessed need up to a maximum of 24 hours per annual certification period.

8.504.2.F. Respite Care shall be provided in the home, in the community, or in an approved respite center location of an eligible MemberClient on a short term basis, not to exceed 30 days per annual certification as determined by the Department approved Assessment. Respite Care shall not be provided at the same time as state plan Home Health or Palliative/Supportive Care services.

1. Respite Care services include any of the following in any combination necessary according to the Support Planning services:

a. Skilled nursing services;

b. Home health aide services; or

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~~c. Personal care services~~

~~8.504.2.G. Palliative/Supportive Care shall not require a nine month terminal prognosis for the Member Client and includes:~~

~~1. Pain and Symptom Management; and~~

~~2. Care Coordination~~

~~8.504.2.H. HCBS-CLLI MemberClients are eligible for all other Medicaid state plan benefits, including Hospice and Home Health.~~

~~8.504.3 NON-BENEFIT~~

~~8.504.3.A. Case Management is not a benefit of the HCBS-CLLI waiver. The Single Entry Point (SEP) provides case management services as an administrative activity.~~

~~8.504.4 MEMBERCLIENT ELIGIBILITY~~

~~8.504.4.A. An eligible MemberClient shall:~~

~~1. Be financially eligible.~~

~~2. Be at risk of institutionalization into a hospital as determined by the SEP case manager using the Department approved assessment tool.~~

~~3. Meet the target population criteria as follows:~~

~~a. Have a life-limiting diagnosis, as certified by a physician on the Department prescribed form, and~~

~~b. Have not yet reached 19 years of age.~~

~~8.504.4.B A MemberClient shall receive at least one HCBS-CLLI waiver benefit per month to maintain enrollment in the waiver.~~

~~1. A MemberClient who has not received at least one HCBS-CLLI waiver benefit during a month shall be discontinued from the waiver.~~

~~2. Case Management does not satisfy the requirement to receive at least one benefit per month on the HCBS-CLLI waiver.~~

~~8.504.5 WAIT LIST~~

~~8.504.5.A. The number of MemberClients who may be served through the waiver at any one time during a year shall be limited by the federally approved HCBS-CLLI waiver document.~~

~~8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-CLLI waiver, who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a wait list maintained by the Department.~~

~~8.504.5.C. The SEP case manager shall ensure the Applicant meets all criteria as set forth in Section 8.504.4.A prior to notifying the Department to place the Applicant on the wait list.~~

~~8.504.5.D. The SEP case manager shall enter the MemberClient's LOC Screen and Professional Medical Information Page data in the IMS and notify the Department by sending the~~

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MemberClient's enrollment information, utilizing the Department's approved form, to the program administrator.

8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish the order of an Applicant's place on the wait list.

8.504.5.F. Within five working days of notification from the Department that an opening for the HCBS-CLLI waiver is available, the SEP case manager shall:

1. Reassess the Applicant for level of care using the Department prescribed Level of Care Screen if the date of the last assessment is more than six months old.

2. Update the current LOC Screen if the date is less than six months old.

3. Reassess for the target population criteria.

4. Notify the Department of the Applicant's eligibility status.

8.504.6 PROVIDER ELIGIBILITY

8.504.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CLLI waiver, enter into an agreement with the Department. Providers must comply with the requirements of Section 8.130.

8.504.6.B. Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure regulations.

8.504.6.C. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

8.504.6.D. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall be one of the following:

1. Licensed Clinical Social Worker (LCSW)

2. Licensed Professional Counselor (LPC)

3. Licensed Social Worker (LSW)

4. Licensed Independent Social Worker (LISW)

5. Licensed Psychologist; or

6. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice agency.

8.504.6.E. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

1. Individuals providing Expressive Therapy delivering art or play therapy services shall meet the requirements for individuals providing Therapeutic Life Limiting Illness Support services and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent MemberClients.

2. Individuals providing Expressive Therapy delivering music therapy services shall hold a Bachelor's, Master's or Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists, and have at least one year of experience in the provision of music therapy to pediatric/adolescent MemberClients.

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~~8.504.6.F. Massage Therapy providers shall have an approved registration and be in good standing with the Colorado Office of Massage Therapy Registration.~~

~~8.504.6.G. Individuals providing Palliative/Supportive Care services shall be employed by or working under a formal contract with a qualified Medicaid hospice or home health agency.~~

~~8.504.6.H. Individuals providing Respite services shall be employed by a qualified Medicaid home health, hospice or personal care agency.~~

~~8.504.7 PROVIDER RESPONSIBILITIES~~

~~8.504.7.A. HCBS-CLLI providers shall have written policies and procedures regarding:~~

~~1. Recruiting, selecting, retaining and terminating employees.~~

~~2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to Section 19-3-307 C.R.S.~~

~~8.504.7.B. HCBS-CLLI providers shall:~~

~~1. Ensure a MemberClient is not discontinued or refused services unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.~~

~~2. Ensure MemberClient records and documentation of services are made available at the request of the case manager.~~

~~3. Ensure that adequate records are maintained.~~

~~a. MemberClient records shall contain:~~

~~i. Name, address, phone number and other identifying information for the MemberClient and the MemberClient's parent(s) and/or legal guardian(s).~~

~~ii. Name, address and phone number of the SEP and the Case Manager.~~

~~iii. Name, address and phone number of the MemberClient's primary physician.~~

~~iv. Special health needs or conditions of the MemberClient.~~

~~v. Documentation of the specific services provided which includes:~~

~~1. Name of individual provider.~~

~~2. The location for the delivery of services.~~

~~3. Units of service.~~

~~4. The date, month and year of services and, if applicable, the beginning and ending time of day.~~

~~5. Documentation of any changes in the MemberClient's condition or needs, as well as documentation of action taken as a result of the changes.~~

~~6. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.02.~~

~~7. Documentation of communication with the MemberClient's SEP case manager.~~

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~~8. Documentation of communication/coordination with other providers.~~

~~b. Personnel records for each employee shall contain:~~

~~i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.~~

~~ii. Documentation of training.~~

~~iii. Documentation of supervision and performance evaluation.~~

~~iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.504.7.A.~~

~~v. A copy of the employee's job description.~~

~~4. Ensure all care provided is coordinated with any other services the MemberClient is receiving.~~

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~~8.504.8 PRIOR AUTHORIZATION REQUESTS.~~

~~8.504.8.A. The SEP case manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CLLI waiver.~~

~~8.504.8.B. All units of service requested shall be listed on the Support Planning form.~~

~~8.504.8.C. The first date for which services may be authorized is the latest date of the following:~~

~~1. The financial eligibility start date, as determined by the financial eligibility site.~~

~~2. The assigned start date on the certification page of the Department approved assessment tool.~~

~~3. The date, on which the MemberClient's parent(s) and/or legal guardian signs the Support Planning form or Intake form, as prescribed by the Department, agreeing to receive services.~~

~~8.504.8.D. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Department approved assessment tool.~~

~~8.504.8.E. The SEP case manager shall submit a revised PAR if a change in the Support Planning results in a change in services.~~

~~8.504.8.F. The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.~~

~~8.504.8.G. Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.~~

~~8.504.8.H. If services are decreased without the MemberClient's parent(s) and/or legal guardian agreement, the SEP case manager shall notify the MemberClient's parent(s) and/or legal guardian of the adverse action and appeal rights using the LTC 803 form in accordance with the 10 day advance notice period.~~

~~8.504.9 REIMBURSEMENT~~

~~8.504.9.A. Providers shall be reimbursed at the lower of:~~

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~~1. Submitted charges; or~~

~~2. A fee schedule as determined by the Department.~~

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[SECTIONS 8.505-8.505.4 REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

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~~**8.506 CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM**~~

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~~**8.506.1 Legal Basis:**~~

~~The Children's Home and Community -based Services program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CHCBS program is also authorized under state law at Section 25.5-6-901, et seq. C.R.S.~~

~~8.506.2 Definitions of Services Provided~~

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~~8.506.2.A Case Management means services as defined at Section 8.390.1 DEFINITIONS and the additional operations specifically defined for this waiver in Section 8.506.4.B.~~

~~8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552~~

~~8.506.3 General Definitions~~

~~A. Assessment means as defined at Section 8.390.1.DEFINITIONS.~~

~~B. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency.~~

~~C. Continued Stay Review means Reassessment as defined in Section 8.390.1 DEFINITIONS.~~

~~D. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital or skilled nursing facility.~~

~~E. County Department means the Department of Human or Social Services in the county where the resident resides.~~

~~F. Department means the Department of Health Care Policy and Financing.~~

~~G. Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.~~

~~H. Institutional Placement means residing in an acute care hospital or nursing facility.~~

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

~~J. Level of Care Screen means as defined in Section 8.390.1.~~

~~K. Level of Care Eligibility Determination means as defined in Section 8.390.1.~~

~~L. Performance and Quality Review means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by a Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements.~~

~~M. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.~~

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N. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery and utilization of services.

O. Professional Medical Information Page (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

P. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1

Q. Utilization Review Contractor (URC) means the agency or agencies contracted with the Department to review the CHCBS waiver application for confirmation that Level of Care eligibility and targeting criteria are met.

8.506.4 Benefits

8.506.4.A Home and Community-based Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at Section 26-1-114, C.R.S.

2. Case Management Agencies will complete all administrative functions of a Member's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of Member's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Member (e.g. natural disaster, pandemic, etc.

b. At the time of making the initial in person contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Member (e.g., natural disaster, pandemic, etc.

c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

d. Verify that the child meets the eligibility requirements outlined in Member Eligibility, Section 8.506.6.

e. Submit the LOC Screen and documentation to the URC to ensure the targeting criteria and level of care eligibility criteria are met. Minimum documents required:

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the Level of Care Determination to the County Department for activation of a Medicaid State Identification Number.

g. Develop the Person-Centered Support Plan in accordance with Section 8.506.4.B.7.

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i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with Section 8.506.10.

4. Continued Stay Review

a. Complete a LOC Screen Reassessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk to the case manager or Member (e.g., natural disaster, pandemic, etc.).

b. Submit the LOC Screen and documentation to the URC to ensure the targeting criteria and Level of Care eligibility criteria are met.

c. Review and revise the Person-Centered Support Plan document in accordance with Section 8.506.4.B.7.

d. Notify the county technician of the renewed Long-term Care certification.

5. Discharge/Withdrawal

a. At the time that the Member no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:

i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.

iii. Submit PAR termination to the Department's Fiscal Agent.

iv. Notify County Department of termination.

v. Notify agencies providing services to the Member that the child has been discharged from the waiver.

6. Transfers

a. Sending agency responsibilities:

i. Contact the receiving case management agency by telephone and provide notification that:

1) The child is planning to transfer, per the parent(s) or guardian choice.

2) Negotiate an appropriate transfer date.

3) Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.

ii. Using a State designated form, notify the URC of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.

iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual 9 CCR 2503-5 Section 3.560 Case Transfers.

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, Section 3.560 is available at Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public

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inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

b. Receiving agency responsibilities

i. Conduct an in person visit with the child within ten (10) working days of the child's transfer. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Member (e.g., natural disaster, pandemic, etc.)., and

ii. Review and revise the Person-Centered Support Plan and change or coordinate services and providers as necessary.

7. Support Planning

a. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community-based services. A signature from the parent(s) or guardian is required on this state designated form.

b. Documentation that the Member was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the Member understands his/her right to change providers

b. On a monthly basis, evaluate the effectiveness of the Support Planning document by monitoring services provided to the child. This monitoring may include:

i. Conducting child, parent(s) or guardian, and provider interviews.

ii. Reviewing utilization data.

iii. Reviewing any written reports received.

8. Performance and Quality Review

a. The Department shall conduct a Performance and Quality Review of the Children's Home and Community-based Services program to ensure that the Case Management Agency is in compliance with all statutory and regulatory requirements.

b. A Case Management Agency found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but not limited to:

i. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;

ii. A detailed timeframe for completing the actions to be taken;

iii. The employee(s) responsible for implementing the actions; and

iv. The estimated date of completion.

c. The Case Management Agency shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The Case Management Agency shall

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explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.

i. Upon receipt of the proposed Corrective Action Plan, the Department will notify the Case Management Agency in writing whether the Corrective Action Plan has been accepted, modified, or rejected.

ii. In the event that the Corrective Action Plan is rejected, the Case Management Agency shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

iii. The Case Management Agency shall begin implementing the Corrective Action Plan upon acceptance by the Department.

iv. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.506.4.C In Home Support Services:

1. IHSS for CHCBS Members shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.

2. Family members of a Member can only be reimbursed for extraordinary care.

8.506.4.D CHCBS Members are eligible for all other Medicaid state plan benefits.

8.506.5 Non-Benefit

8.506.5.A Tasks defined as Personal Care or Homemaker in Section 8.552 are not benefits of this waiver.

8.506.6 Member Eligibility

8.506.6.A An eligible Member shall meet the following requirements:

1. Targeting Criteria:

a. Not have reached his/her eighteenth (18th) birthday.

b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Level of Care Eligibility:

a. The URC certifies, through the Case Management Agency completed LOC Screen, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.

3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.

4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

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~~8.506.6.B Financial Eligibility~~

~~1. Parental income and/or resources will result in the child being ineligible for Medicaid benefits.~~

~~2. The income and resources of the child do not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance~~

~~3. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, Long-Term Care Medical Assistance Eligibility, Consideration of Trusts in Determining Medicaid Eligibility, Section 8.100.7.E.~~

~~8.506.6.C Roles of the County Department~~

~~1. Processing the Disability Determination Application through the contracted entity determined by the Department.~~

~~2. Certify that the child's income and/or resources does not exceed 300% of SSI.~~

~~3. Ensure that the parent(s) or guardian is in contact with a case management agency.~~

~~4. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility within five (5) workings days of determination.~~

~~8.506.7 Waiting List~~

~~8.506.7.A The number of Members who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.~~

~~8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.~~

~~8.506.7.C The waiting list shall be maintained by the URC.~~

~~8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the URC will use for the individual's placement on the waiting list.~~

~~8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.~~

~~8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.~~

~~8.506.7.G When an opening for the CHCBS waiver becomes available the URC will provide written notice to the Case Management Agency.~~

~~8.506.7.H Within ten business days of notification from the URC that an opening for the CHCBS waiver is available the Case Management Agency shall:~~

~~1. Reassess the individual using the Department's prescribed LOC Screen instrument if more than six months has elapsed since the previous assessment.~~

~~2. Update the existing Level of Care Screen in the official Member record.~~

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3. Reassess for eligibility criteria as set forth at 8.506.6.

4. Notify the URC of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.8 Provider Eligibility

8.506.8.A Providers shall enter into an agreement with the Department to conform to all federal and state established standards for the specific service they provide under the HCBS-CHCBS waiver.

8.506.8.B Providers must comply with the requirements of Section 8.130.

8.506.8.C Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure statute and regulations.

8.506.8.D IHSS providers shall comply with IHSS Rules in Section 8.552.

8.506.9 Provider Responsibilities

8.506.9.A CHCBS providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining, and terminating employees;

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to Section 19-3-307 C.R.S.

8.506.9.B CHCBS Providers shall:

1. Ensure a Member is not discontinued or refused services unless documented reasonable efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure Member records and documentation of services are made available at the request of the case manager, Department, or URC.

3. Ensure that adequate records are maintained.

a. Member records shall contain:

i. Name, address, phone number and other identifying information for the Member and the Member's parent(s) and/or legal guardian(s).

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ii. Name, address and phone number of child's Case Manager.

iii. Name, address and phone number of the Member's primary physician.

iv. Special health needs or conditions of the Member.

v. Documentation of the specific services provided, including:

a. Name of individual provider.

b. The location for the delivery of services.

c. Units of service.

d. The date, month and year of services and, if applicable, the beginning and ending time of day.

x. Documentation of any changes in the Member's condition or needs, as well as documentation of action taken as a result of the changes.

xi. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.2.

xii. Documentation of communication with the Member's case manager.

xiii. Documentation of communication/coordination with any additional providers.

b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.506.

v. A copy of the employee's job description.

4. Ensure all care provided is coordinated with any other services the Member is receiving.

8.506.9.C Responsibilities specific to IHSS Provider Agencies

1. Eligible IHSS Agencies will conform to all certification standards set forth at 10 C.C.R 2505-10, Section 8.552.5

2. IHSS Agencies will adhere to all responsibilities outlined at 10 C.C.R. 2505.10, Section 8.552.6

3. Ensure that only Health Maintenance Activities are delivered to CHCBS Members through the IHSS benefit.

8.506.9.D Responsibilities Specific to Case Management Agencies

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1. Case Management Agencies will obtain a specific authorization to provide CHCBS case management benefits to Members as set forth in Provider Enrollment Section 8.487.

2. Verify that the IHSS care plan developed by IHSS providers is in accordance with both Sections 8.506.4.C and 8.552 of this volume.

3. Case Management Agencies must submit all documentation requested by the Department to complete a Performance and Quality Review within the timeframe specified by the Department.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the Person-Centered Support Plan.

8.506.10.C The first date for which services can be authorized is the latest date of the following:

1. The financial eligibility start date, as determined by the financial eligibility site.

2. The assigned start date on the Level of Care Eligibility Determination.

3. The date, on which the Member's parent(s) and/or legal guardian signs the Person-Centered Support Plan or Intake form, as prescribed by the Department, agreeing to receive services.

8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the Level of Care Eligibility Determination.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Person-Centered Support Plan results in a change in services.

8.506.10.F The revised Person-Centered Support Plan shall list the service being changed and state the reason for the change. Services on the revised Person-Centered Support Plan, plus all services on the original document, shall be entered on the revised PAR.

8.506.10.G Revisions to the Person-Centered Support Plan requested by providers after the end date on a PAR shall be disapproved.

8.506.10.H The Long-Term Care Notice of Action Form (LTC-803) shall be completed in the Information Management System (IMS), as defined in Section 8.390.1 DEFINITIONS for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, or at the time of discontinuation.

8.506.11 Reimbursement

8.506.11.A Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

8.506.12 Cost Containment

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~~8.506.12.A The Department is responsible for ensuring that, on average, services delivered to the child are within the Department's cost containment requirements for the respective level of institutional care. Cost Containment includes;~~

~~1. Waiver benefit services and units, as defined at 8.506.2.~~

~~2. State Plan benefit services and units.~~

~~8.506.12.B The case manager must ensure cost effectiveness as part of the Support Planning process.~~

~~8.506.12.C The costs of the benefit services shall be totaled and divided by the number of days remaining before the end of the child's current enrollment period.~~

~~8.506.12.D The cost per day for the child shall be compared against the Department designated cost per day of institutional care to determine cost effectiveness.~~

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[SECTION 8.507 REMAINS UNCHANGED AND IS NOT AFFECTED BY THIS RULEMAKING]

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~~8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM~~

~~8.508.10 LEGAL BASIS~~

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~~The Home and Community based Services- Children's Habilitation Residential Program (HCBS-CHRP) is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a. The waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n.~~

~~8.508.20 DEFINITIONS~~

~~A. Abuse: As defined at § 16-22-102 (9) C.R.S., § 19-1-103, C.R.S., § 25.5-10-202 (1) (a)-(c), C.R.S., and § 26.3.1-101 C.R.S.~~

~~B. Adverse Action: A denial, reduction, termination, or suspension from a Long-Term Services and Supports (LTSS) program or service.~~

~~C. Applicant: A child or youth who is seeking a Long-Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.~~

~~D. Assessment: As defined in Section 8.390.1 DEFINITIONS.~~

~~E. Caretaker: As defined at Section 25.5-10-202 (1.6)(a)-(c), C.R.S.~~

~~F. Caretaker neglect: As defined at Section 25.5-10-202 (1.8)(a)-(c), C.R.S.~~

~~G. Case Management Agency (CMA): A public or private not-for-profit for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to sections 25.5-10-209.5 C.R.S. and pursuant to a provider participation agreement with the state department.~~

~~H. Child Placement Agency: As defined at 12 CCR 2509-8; Section 7.701.2 (F).~~

~~I. MemberClient: A child or youth who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-based Services (HCBS)~~

~~J. MemberClient Representative: A person who is designated to act on the MemberClient's behalf. A MemberClient Representative may be: (a) a legal representative including, but not limited to a court-appointed guardian, or a parent of a minor child; or (b) an individual, family member or friend selected by the MemberClient to speak for an/or act on the MemberClient's behalf.~~

~~K. Community Centered Board: A private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-based Service waivers specific to individuals with intellectual and developmental disabilities, and management of state funded programs for individuals with intellectual and developmental disabilities.~~

~~L. Complex Behavior: Behavior that occurs related to a diagnosis by a licensed physician, psychiatrist, or psychologist that includes one or more substantial disorders of the cognitive, volitional or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior.~~

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M. Complex Medical Needs: Needs that occur as a result of a chronic medical condition as diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12) months, requires skilled care, and that without intervention may result in a severely life altering condition.

N. Cost Containment: Limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-based Services, and Medicaid State Plan benefits including long- term home health services and targeted case management.

O. Criminal Activity: A criminal offense that is committed by a person; a violation of parole or probation; and any criminal offense that is committed by a person receiving services that results in immediate incarceration.

P. Crisis: An event, series of events, and/or state of being greater than normal severity for the MemberClient and/or family that becomes outside the manageable range for the MemberClient and/or their family and poses a danger to self, family, and/or the community. Crisis may be self-identified, family identified, and/or identified by an outside party.

Q. Critical Incident: Incidents of Mistreatment; Abuse; Neglect; Exploitation, Criminal Activity; Damage to MemberClient's Property/Theft; Death unexpected or expected; Injury/Illness to MemberClient; Medication Mismanagement; Missing Person; Unsafe Housing/Displacement; and/or Other Serious Issues.

R. Department: The Colorado Department of Health Care Policy and Financing the single state Medicaid agency.

S. Damage to MemberClient's Property/Theft: Deliberate damage, destruction, theft or use a MemberClient's belongings or money. If the incident involves Mistreatment by a Caretaker that results in damage tor MemberClient's property or theft in the incident shall be listed as Mistreatment.

Developmental Delay: A child who is:

1. Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:

i. Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age;

ii. Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development;

iii. Has an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or

2. Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a CCB.

T. Early and Periodic Screening Diagnosis and Treatment (EPSDT): As defined in Section 8.280.1.

U. Exploitation: As defined in Sections 25.5-10-202(15.5)(a)-(d) and 26.3.1-101 C.R.S.

V. Extraordinary Needs: A level of care due to Complex Behavior and/or Medical Support Needs that is provided in a residential child care facility or that is provided through community-

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based programs, and without such care, would place a child at risk of unwarranted child welfare involvement or other system involvement.

W. Family: As defined at Section 25.5-10-202 (16)(a)(I)-(IV)(b), C.R.S.

X. Foster Care Home: A family care home providing 24-hour care for a child or children and certified by either a County Department of Social/Human Services or a child placement agency. A Foster Care Home, for the purposes of this waiver, shall not include a family member as defined in Section 25.10-202 (16)(a)(I)-(IV)(b), C.R.S.

Y. Guardian: An individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not guardian ad litem.

Z.. Guardian ad litem or GAL: A person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963", set forth in Article 33 of Title 22, C.R.S.

AA. Harmful Act: as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.

BB. Home and Community-based Services (HCBS) Waivers: Services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a MemberClient who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

CC. Increased Risk Factors: Situations or events that when occur at a certain frequency or pattern historically have led to Crisis.

DD. Informed Consent: An assent that is expressed in writing, freely given, and preceded by the following:

1. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

2. A description of the attendant discomforts and risks;

3. A description of the expected benefits;

4. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

5. An offer to answer any inquiries regarding the procedure(s);

6. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

7. A statement that withholding or withdrawal of consent shall not prejudice future availability of services and supports.

EE. Injury/Illness to MemberClient: An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, and skin wounds; an injury or illness requiring immediate emergency medical treatment to preserve life or limb; an emergency medical treatment that results in admission to the hospital; and a psychiatric crisis resulting in unplanned hospitalization.

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~~FF. Institution: A hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the State Plan.~~

~~GG. Intellectual and Developmental Disability: A disability that manifests before the person reaches twenty-two (22) years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15001 et seq., does not apply.~~

~~"Impairment of general intellectual functioning" The person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. when an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.~~

~~"Adaptive behavior similar to that of a person with intellectual and developmental disabilities" The person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.~~

~~"Substantial intellectual deficits" An intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.~~

~~HH. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID): A publicly or privately-operated facility that provides health and habilitation services to a Member~~Client ~~with intellectual or developmental disabilities or related conditions.~~

~~II. Kin: As defined in 12 CCR 2509-1, Section 7.000.2.A.~~

~~JJ. Kinship Foster Care Home: As defined in 12 CCR 2509-1, Section 7.000.2.A.~~

~~KK. Level of Care (LOC): The specified minimum amount of assistance a Member~~Client ~~must require in order to receive services in an institutional setting under the Medicaid State Plan.~~

~~LL. Level of Care Eligibility Determination: As defined in Section 8.390.1.~~

~~MM. Level of Care Eligibility Determination Screen: As defined in Section 8.390.1.~~

~~NN. Licensed Child Care Center (less than 24 hours): As defined in Section 26-6-102 (5), C.R.S. and as described in 12 CCR 2509-8; Section 7.701.~~

~~OO. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Member~~Clients ~~of all ages with functional limitations and chronic illnesses~~

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who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

PP. Medicaid Eligible: The Applicant or MemberClient meets the criteria for Medicaid benefits based on the financial determination and disability determination.

QQ. Medicaid State Plan: The federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

RR. Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

SS. Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or there is a risk to public safety.

TT. "Mistreated" or "Mistreatment": As defined at Section 25.5-10-202(29.5)(a)-(d) and 26.3.1-101.

UU. Natural Supports: Unpaid informal relationships that provide assistance and occur in the MemberClient's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

VV. Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.

WW. Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or lesser likelihood of success of Crisis interventions.

XX. Prior Authorization: Approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the CMA.

YY. Professional: Any person, not including family, performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

ZZ. Professional Medical Information Page (PMIP): as defined in Section 8.390.1 DEFINITIONS.

AAA. Relative: A person related to the MemberClient by blood, marriage, adoption or common law marriage.

BBB. Residential Child Care Facility: As defined in 12 CCR 2509-8, Section 7.705.1.

CCC. Retrospective Review: The Department's review after services and supports are provided to ensure the MemberClient received services according to the PCSP and standards of economy, efficiency and quality of service.

DDD. Separation: The restriction of a MemberClient for a period of time to a designated area from which the is not physically prevented from leaving, for the purpose of providing the MemberClient an opportunity to regain self-control.

EEE. Service Provider: A Specialized Group Facility, Residential Child Care Facility, Foster Care Home, Kinship Foster Care Home, Child Placement Agency, Licensed Child Care Facility (non-24 hours), and/or Medicaid enrolled provider.

FFF. Person-Centered Support Plan (PCSP): Defined in Section 8.390.1 DEFINITIONS.

GGG. Person-Centered Support Planning (PCSP): Defined in Section 8.390.1 DEFINITIONS.

HHH. Specialized Group Facility: As defined in 12 CCR 2509-8; Section 7.701.2(B).

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~~III. Support: Any task performed for the MemberClient where learning is secondary or incidental to the task itself or an adaptation is provided.~~

~~JJJ. Support Level: A numeric value determined by the Support Need Level Assessment that places MemberClients into groups with other MemberClients who have similar overall support needs.~~

~~KKK. Support Need Level Assessment: The standardized assessment tool used to identify and measure the support requirements for HCBS-CHRP waiver participants.~~

~~LLL. Targeted Case Management (TCM): Has the same meaning as in Section 8.761.~~

~~MMM. Third Party Resources: Services and supports that a MemberClient may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to community resources, services provided through private insurance, non-profit services and other government programs.~~

~~NNN. Unsafe Housing/Displacement: An individual residing in an unsafe living condition due to a natural event (such as fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.~~

~~OOO. Waiver Service: Optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.~~

~~PPP. Wraparound Facilitator: A person who has a bachelor's degree in a human behavioral science or related field of study and is certified in a wraparound training program. Experience working with LTSS populations in a private or public social services agency may substitute for the bachelor's degree on a year for year basis. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field. The wraparound certification must include training in the following:~~

~~Trauma informed care.~~

~~Youth mental health first aid.~~

~~Crisis supports and planning.~~

~~Positive Behavior Supports, behavior intervention, and de-escalation techniques.~~

~~Cultural and linguistic competency.~~

~~Family and youth serving systems.~~

~~Family engagement.~~

~~Child and adolescent development.~~

~~Accessing community resources and services.~~

~~Conflict resolution.~~

~~Intellectual and developmental disabilities.~~

~~Mental health topics and services.~~

~~Substance abuse topics and services.~~

~~Psychotropic medications.~~

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~~Motivational interviewing.~~

~~Prevention, detection, and reporting of Mistreatment, Abuse, Neglect, and Exploitation.~~

~~QQQ. Wraparound Transition Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a MemberClient and his or her family, including a transition to the family home after out of home placement.~~

~~RRR. Wraparound Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a MemberClient and his or her family, including a plan to maintain stabilization, prevent Crisis, and/or for de-escalation of Crisis situations.~~

~~SSS. Wraparound Support Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the MemberClient and his or her family.~~

~~TTT. Wraparound Transition Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the MemberClient and his or her family.~~

~~8.508.30 SCOPE OF SERVICES~~

~~A. The HCBS-CHRP waiver provides services and supports to eligible children and youth with Intellectual and Developmental Disability, and who are at risk of institutionalization pursuant to 25.5-6-903, C.R.S. The services provided through this waiver serve as an alternative to ICF-/IID placement for children from birth to twenty-one years (21) of age who meet the eligibility criteria and the Level of Care as determined by a Level of Care Evaluation and Determination. The services provided through the HCBS-CHRP waiver are limited to:~~

~~1. Habilitation~~

~~2. Hippotherapy~~

~~3. Intensive Support~~

~~4. Massage Therapy~~

~~5. Movement Therapy~~

~~6. Respite~~

~~7. Supported Community Connection~~

~~8. Transition Support~~

~~B. HCBS-CHRP waiver services shall be provided in accordance with these rules and regulations.~~

~~8.508.40 ELIGIBILITY~~

~~A. Services shall be provided to MemberClients with an Intellectual and Developmental Disability who meet all of the following eligibility requirements:~~

~~1. A determination of developmental disability by a CCB which includes developmental delay if under five (5) years of age.~~

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2. The MemberClient has Extraordinary Needs that put the MemberClient at risk of, or in need of, out of home placement.

3. Meet ICF-IID Level of Care as determined by a LOC Screen.

4. The income of the MemberClient does not exceed 300% of the current maximum SSI standard maintenance allowance.

5. Enrollment of the MemberClient in the HCBS- CHRP waiver will result in an overall savings when compared to the ICF-/IID cost as determined by the State.

6. The MemberClient receives at least one waiver service each month.

B. A Support Need Level Assessment must be completed upon determination of eligibility. The Support Need Level Assessment is used to determine the level of reimbursement for Habilitation and per diem Respite services.

C. MemberClients must first access all benefits available under the Medicaid State Plan and/or EPSDT for which they are eligible, prior to accessing funding for those same services under the HCBS-CHRP waiver.

D. Pursuant to the terms of the HCBS-CHRP waiver, the number of individuals who may be served each year is based on:

1. The federally approved capacity of the waiver;

2. Cost Containment requirements under section 8.508.80;

3. The total appropriation limitations when enrollment is projected to exceed spending authority.

8.508.50 WAITING LIST PROTOCOL

A. MemberClients determined eligible for HCBS-CHRP services who cannot be served within the appropriation capacity limits of the HCBS-CHRP waiver shall be eligible for placement on a waiting list.

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

2. The date used to establish the MemberClient's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.508.40 were determined to have been met and the Department was notified.

3. As openings become available within the appropriation capacity limits of the federal waiver, MemberClients shall be considered for services based on the date of their waiting list placement.

8.508.60 RESPONSIBILITIES OF THE CMACB

A. The CMACB shall make eligibility determinations for developmental disabilities services to include the Level of Care Eligibility Determination for any Applicant or MemberClient being considered for enrollment in the HCBS-CHRP waiver.

B. Additional administrative responsibilities of CMACBs as required in 8.601.

8.508.70 CASE MANAGEMENT FUNCTIONS

A. Case management services will be provided by a CMA as a Targeted Case Management service pursuant to sections 8.761.14 and 8.519 and will include:

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1. Completion of a LOC Screen

2. Completion of a Person-Centered Support Plan (PCSP);

3. Referral for services and related activities;

4. Monitoring and follow-up by the CMA including ensuring that the SP is implemented and adequately addresses the MemberClient's needs.

5. Monitoring and follow-up actions, which shall

a. Be performed when necessary to address health and safety and services in the PCSP;

b. Services in the PCSP are adequate; and

c. Necessary adjustments in the PCSP and service arrangements with providers are made if the needs of the MemberClient have changed.

6. Face to face monitoring to be completed at least once per quarter and to include direct contact with the MemberClient in a place where services are delivered. Upon Department approval, monitoring may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or MemberClient (e.g. natural disaster, pandemic, etc.).

8.508.71 SERVICE PLAN (SP)

A. The CMA shall complete a Service Plan for each MemberClient enrolled in the HCBS-CHRP waiver in accordance with Section 8.519.11.B and will:

1. Address the MemberClient's assessed needs and personal goals, including health and safety risk factors either by HCBS-CHRP waiver services or any other means;

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

3. Be entered and verified in the Department prescribed system within ten (10) business days;

4. Describe the types of services to be provided, the amount, frequency, and duration of each service and the provider type for each service;

5. Include a statement of agreement by the MemberClient and/or the legally responsible party; and

6. Be updated or revised at least annually or when warranted by changes in the MemberClient's needs.

B. The Service Plan shall document that the Member Client has been offered a choice:

1. Between HCBS waivers and institutional care;

2. Among HCBS-CHRP waiver services; and

3. Among qualified providers.

8.508.72 PRIOR AUTHORIZATION REQUESTS (PAR)

A. The case manager shall submit a PAR in compliance with applicable regulations and ensure requested services are:

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~~1. Consistent with the MemberClient's documented medical condition and Comprehensive Assessment.~~

~~2. Adequate in amount, frequency, scope and duration in order to meet the MemberClient's needs and within the limitations set forth in the current federally approved HCBS-CHRP waiver.~~

~~3. Not duplicative of another service, including services provided through:~~

~~a. Medicaid State Plan benefits;~~

~~b. Third Party Resources;~~

~~c. Natural Supports;~~

~~d. Charitable organizations; or~~

~~e. Other public assistance programs.~~

~~B. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to Section 8.058.4.~~

~~8.508.73 REIMBURSEMENT~~

~~A. Only services identified in the Service Plan are available for reimbursement under the HCBS-CHRP waiver. Reimbursement will be made only to licensed or certified providers, as defined in Section 8.508.160 and services will be reimbursed per a fee for service schedule as determined by the Department through the Medicaid Management Information System (MMIS).~~

~~B. Only those services not available under Medicaid EPSDT, Medicaid State Plan benefits, Third Party Resources, or other public funded programs, services or supports are available through the CHRP Waiver. All available community services must be exhausted before requesting similar services from the waiver. The CHRP Waiver does not reimburse services that are the responsibility of the Colorado Department of Education.~~

~~C. Reimbursement for Habilitation service does not include the cost of normal facility maintenance, upkeep and improvement. This exclusion does not include costs for modifications or adaptations required to assure the health and safety of MemberClient or to meet the requirements of the applicable life safety code.~~

~~D. Medicaid shall not pay for room and board.~~

~~E. Claims for Targeted Case Management are reimbursable pursuant to Section 8.761.4-.5.~~

~~8.508.74 COMPLIANCE MONITORING~~

~~A. Services provided to a MemberClient are subject to compliance monitoring by the Department pursuant to Section 8.076.2.~~

~~8.508.80 COST CONTAINMENT~~

~~Cost Containment is to ensure, on an individual MemberClient basis, that the provision of HCBS-CHRP services is a cost-effective alternative compared to the equivalent cost of appropriate ICF-/IID institutional Level of Care. The Department shall be responsible for ensuring that, on average, each Service Plan is within the federally approved Cost Containment requirements of the waiver. MemberClients enrolled in the HCBS-CHRP waiver shall continue to meet the Cost Containment criteria during subsequent periods of eligibility.~~

~~8.508.100 SERVICE DESCRIPTIONS~~

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~~A. Habilitation~~

~~1. Services may be provided to MemberClients who require additional care for the MemberClient to remain safely in home and community-based settings. The MemberClient must demonstrate the need for such services above and beyond those of a typical child of the same age.~~

~~2. Habilitation services include those that assist MemberClients in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.~~

~~3. Habilitation services under the HCBS-CHRP waiver differ in scope, nature, supervision, and/or provider type (including provider training requirements and qualifications) from any other services in the Medicaid State Plan.~~

~~4. Habilitation is a twenty-four (24) hour service and includes the following activities:~~

~~a. Independent living training, which may include personal care, household services, infant and childcare when the MemberClient has a child, and communication skills.~~

~~b. Self-advocacy training and support which may include assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing Abuse, Neglect, Mistreatment, and/or Exploitation of self, responsibility for one's own actions, and participation in meetings.~~

~~c. Cognitive services which includes assistance with additional concepts and materials to enhance communication.~~

~~d. Emergency assistance which includes safety planning, fire and disaster drills, and crisis intervention.~~

~~e. Community access supports which includes assistance developing the abilities and skills necessary to enable the MemberClient to access typical activities and functions of community life such as education, training, and volunteer activities. Community access supports includes providing a wide variety of opportunities to develop socially appropriate behaviors, facilitate and build relationships and Natural Supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the MemberClient's Service Plan. These activities are conducted in a variety of settings in which the MemberClient interacts with non-disabled individuals (other than those individuals who are providing services to the MemberClient). These services may include socialization, adaptive skills, and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement and are based on the interest of the MemberClient.~~

~~f. Transportation services are encompassed within Habilitation and are not duplicative of the non-emergent medical transportation that is authorized in the Medicaid State Plan. Transportation services are more specific to supports provided by Foster Care Homes, Kinship Foster Care Homes, Specialized Group Facilities, and Residential Child Care Facilities to access activities and functions of community life.~~

~~g. Follow-up counseling, behavioral, or other therapeutic interventions, and physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.~~

~~h. Medical and health care services that are integral to meeting the daily needs of the MemberClient and include such tasks as routine administration of medications or providing support when the MemberClient is ill.~~

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5. Habilitation may be provided in a Foster Care Home or Kinship Foster Care Home certified by a licensed Child Placement Agency or County Department of Human Services, Specialized Group Facility licensed by the Colorado Department of Human Services, or Residential Child Care Facility licensed by the Colorado Department of Human Services.

6. Habilitation may be provided for memberclients age eighteen (18) to twenty (20) in a Host Home. The Host Home must meet all requirements as defined in Section 8.600.

7. Service Providers and child placement agencies must not exceed habilitation capacity limits at 12 CCR 2509-8; §§ 7.701.2, 7.708.1.A.2, 7.710.48.C.

8. Only one (1) HCBS-CHRP MemberClient and two (2) HCBS- Persons with Developmental Disabilities (DD) or HCBS- Supported Living Services (SLS) waiver participants; or two (2) HCBS-CHRP participants and one HCBS-DD or HCBS-SLS waiver participant may live in the same foster care home.

9. The Service Provider or child placement agency shall ensure choice is provided to all MemberClients in their living arrangement.

10. The Foster Care Home or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all MemberClients living in the home.

11. The Service Provider shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification before any child or youth can be placed in that home. If emergency placement is needed outside of business hours, the Service Provider or child placement agency shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification the next business day.

B. Hippotherapy

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

2. Hippotherapy may be provided only when the provider is licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

3. Hippotherapy must be used as a treatment strategy for an identified medical or behavioral need.

4. Hippotherapy must be an identified need in the Service Plan.

5. Hippotherapy must be recommended or prescribed by a licensed physician or therapist who is enrolled as a Medicaid provider. The recommendation must clearly identify the need for hippotherapy, recommended treatment, and expected outcome.

6. The recommending therapist or physician must monitor the progress of the hippotherapy treatment at least quarterly.

7. Hippotherapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT, or from a Third-Party Resource.

8. Equine therapy and therapeutic riding are excluded.

C. Intensive Support

1. This service aligns strategies, interventions, and supports for the MemberClient, and family, to prevent the need for out of home placement.

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~~2. This service may be utilized in maintaining stabilization, preventing Crisis situations, and/or de-escalation of a Crisis.~~

~~3. Intensive support services include:~~

~~a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the child or youth and family.~~

~~b. Identification of needs for Crisis prevention and intervention including, but not limited to:~~

~~i. Cause(s) and triggers that could lead to a Crisis.~~

~~ii. Physical and behavioral health factors.~~

~~iii. Education services.~~

~~iv. Family dynamics.~~

~~v. Schedules and routines.~~

~~vi. Current or history of police involvement.~~

~~vii. Current or history of medical and behavioral health hospitalizations.~~

~~viii. Current services.~~

~~ix. Adaptive equipment needs.~~

~~x. Past interventions and outcomes.~~

~~xi. Immediate need for resources.~~

~~xii. Respite services.~~

~~xiii. Predictive Risk Factors.~~

~~xiv. Increased Risk Factors.~~

~~4. Development of a Wraparound Plan with action steps to implement support strategies, prevent, and/or manage a future Crisis to include, but not limited to:~~

~~a. The unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Member~~Client and family.~~~~

~~b. Environmental modifications.~~

~~c. Support needs in the family home.~~

~~d. Respite services.~~

~~e. Strategies to prevent Crisis triggers.~~

~~f. Strategies for Predictive and/or Increased Risk Factors.~~

~~g. Learning new adaptive or life skills.~~

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~~h. Behavioral or other therapeutic interventions to further stabilize the MemberClient emotionally and behaviorally and to decrease the frequency and duration of any future behavioral Crises.~~

~~i. Medication management and stabilization.~~

~~j. Physical health.~~

~~k. Identification of training needs and connection to training for family members, Natural Supports, and paid staff.~~

~~l. Determination of criteria to achieve stabilization in the family home.~~

~~m. Identification of how the plan will be phased out once the MemberClient has stabilized.~~

~~n. Contingency plan for out of home placement.~~

~~o. Coordination among Family caregivers, other Family members, service providers, Natural Supports, Professionals, and case managers required to implement the Wraparound Plan.~~

~~p. Dissemination of the Wraparound Plan to all individuals involved in plan implementation.~~

~~5. Child and Youth Mentorship.~~

~~a. The type, frequency, and duration of in-home support services must be included in a Wraparound Plan.~~

~~b. Child and Youth Mentorship includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the child or youth with self-care, learning self-advocacy, and protective oversight.~~

~~c. Service may be provided in the MemberClient's home or community as determined by the Wraparound Plan.~~

~~6. Follow-up services.~~

~~a. Follow-up services include an evaluation to ensure that triggers to the Crisis have been addressed in order to maintain stabilization and prevent a future Crisis.~~

~~b. An evaluation of the Wraparound Plan should occur at a frequency determined by the MemberClient's needs and include at a minimum, visits to the MemberClient's home, review of documentation, and coordination with other Professionals and/or members of the Wraparound Support Team to determine progress.~~

~~c. Services include a review of the MemberClient's stability and monitoring of Increased Risk Factors that could indicate a repeat Crisis.~~

~~d. Revision of the Wraparound Plan should be completed as necessary to avert a Crisis or Crisis escalation.~~

~~e. Services include ensuring that follow-up appointments are made and kept.~~

~~7. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the MemberClient, their Family, and their Wraparound Support Team.~~

~~8. All service and supports providers on the Wraparound Support Team must adhere to the Wraparound Plan.~~

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~~9. Revision of strategies should be a continuous process by the Wraparound Support Team in collaboration with the MemberClient, until the MemberClient is stable and there is no longer a need for Intensive Support Services.~~

~~10. On-going evaluation after completion of the Wraparound Plan may be provided if there is a need to support the MemberClient and his or her Family in connecting to any additional resources needed to prevent a future Crisis.~~

~~D. Massage Therapy~~

~~1. Massage therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation, and muscle tension including WATSU.~~

~~2. Children with specific developmental disorders often experience painful muscle contractions. Massage has been shown to be an effective treatment for easing muscle contracture, releasing spasms, and improving muscle extension, thereby reducing pain.~~

~~3. Massage therapists must be licensed, certified, registered, and/or accredited by an appropriate national accreditation association.~~

~~4. The service must be used as a treatment strategy for an identified medical or behavioral need and included in the Service Plan.~~

~~5. Massage therapy services must be recommended or prescribed by a therapist or physician who is an enrolled Medicaid Provider. The recommendation must include the medical or behavioral need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the massage therapy treatment at least quarterly.~~

~~6. Massage therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.~~

~~E. Movement Therapy~~

~~1. Movement therapy is the use of music therapy and/or dance therapy as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills.~~

~~2. Movement therapy providers must be meet the educational requirements and is certified, registered and/or accredited by an appropriate national accreditation association.~~

~~3. Movement therapy is only authorized as a treatment strategy for a specific medical or behavioral need and identified in the MemberClient's Service Plan.~~

~~4. Movement therapy must be recommended or prescribed by a therapist or physician who is enrolled Medicaid provider. The recommendation must include the medical need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the movement therapy at least quarterly.~~

~~5. Movement Therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.~~

~~F. Respite~~

~~1. Respite services are provided to children or youth living in the Family home on a short-term basis because of the absence or need for relief of the primary Caretaker(s)~~

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2. Respite services may be provided in a certified Foster Care Home, Kinship Foster Care Home, Licensed Residential Child Care Facility, Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours), in the Family home, or in the community.

3. Federal financial participation is not available for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

4. The total amount of respite provided in one Service Plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units, where one unit is equal to 15 minutes. The Department may approve a higher amount when needed due to the Memberclient's age, disability or unique family circumstances.

5. During the time when Respite care is occurring, the Foster Care Home or Kinship Care Home may not exceed six (6) foster children or a maximum of eight (8) total children, with no more than two (2) children under the age of (two) 2. The respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.

6. Respite is available for children or youth living in the Family home and may not be utilized while the MemberClient is receiving Habilitation services.

G. Community Connector

1. Community Connector services are provided one-on-one to deliver instruction for documented Complex Behavior that are exhibited by the MemberClient while in the community, such as physically or sexually aggressive behavior towards others and/or exposing themselves.

2. Services must be provided in a setting within the community where the MemberClient interacts with individuals without disabilities (other than the individual who is providing the service to the MemberClient).

3. The targeted behavior, measurable goal(s), and plan to address must be clearly articulated in the Service Plan.

4. This service is limited to 260 hours or 1040 units per year.

5. A request to increase service hours can be made to the Department on a case-by-case basis.

H. Transition Support

1. Transition support services align strategies, interventions, and Supports for the MemberClient, and Family, when a MemberClient transitions to the Family home from out-of-home placement.

2. Services include:

a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the MemberClient and Family.

b. Identification of transition needs including, but not limited to:

i. Cause(s) of a Crisis and triggers that could lead to a Crisis.

ii. Physical and behavioral health factors.

iii. Education services.

iv. Family dynamics.

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~~v. Schedules and routines.~~

~~vi. Current or history of police involvement.~~

~~vii. Current or history of medical and behavioral health hospitalizations.~~

~~viii. Current services.~~

~~ix. Adaptive equipment needs.~~

~~x. Past interventions and outcomes.~~

~~xi. Immediate need for resources.~~

~~xii. Respite services.~~

~~xiii. Predictive Risk Factors.~~

~~xiv. Increased Risk Factors.~~

~~3. Development of a Wraparound Transition Plan is required, with action steps to implement strategies to address identified transition risk factors including, but not limited to:~~

~~a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Member~~Client and Family.

~~b. Environmental modifications.~~

~~c. Strategies for transition risk factors.~~

~~d. Strategies for avoiding Crisis triggers.~~

~~e. Support needs in the Family home.~~

~~f. Respite services.~~

~~g. Learning new adaptive or life skills.~~

~~h. Counseling/behavioral or other therapeutic interventions to further stabilize the Member~~Client emotionally and behaviorally to decrease the frequency and duration of future Crises.

~~i. Medication management and stabilization.~~

~~j. Physical health.~~

~~k. Identification of training needs and connection to training for Family members, Natural Supports, and paid staff.~~

~~l. Identification of strategies to achieve and maintain stabilization in the Family home.~~

~~m. Identification of how the Wraparound Plan will terminate once the child or youth has stabilized.~~

~~n. Coordination among Family, service providers, natural supports, professionals, and case managers required to implement the Wraparound Transition Plan.~~

~~o. Dissemination of a Wraparound Transition Plan to all involved in plan implementation.~~

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~~4. Child and Youth Mentorship~~

~~a. The type, frequency, and duration of authorized services must be included in the Wraparound Plan.~~

~~b. Child and Youth Mentorship includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the MemberClient with self-care, learning self-advocacy, and protective oversight.~~

~~c. Services may be provided in the MemberClient's home or in community, as provided in the Wraparound Transition Plan.~~

~~5. Follow-up services are authorized and may include:~~

~~a. Evaluation to ensure the Wraparound Transition Plan is effective in the MemberClient achieving and maintaining stabilization in the Family home.~~

~~b. Evaluation of the Wraparound Transition plan to occur at a frequency determined by the MemberClient's needs and includes but is not limited to, visits to the MemberClient's home, review of documentation, and coordination with other professionals and/or members of the Wraparound Transition Support Team to determine progress.~~

~~c. Reviews of the MemberClient's stability and monitoring of Predictive Risk Factors that could indicate a return to Crisis.~~

~~d. Revision of the Wraparound Plan as needed to avert a Crisis or Crisis escalation.~~

~~e. Ensuring that follow-up appointments are made and kept.~~

~~6. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the MemberClient, their family, and their Wraparound Transition Team.~~

~~7. All service providers and supports on the Wraparound Transition Team must adhere to the Wraparound Transition Plan.~~

~~8. Revision of strategies should be a continuous process by the Wraparound Transition Team in collaboration with the MemberClient, until stabilization is achieved and there is no longer a need for Transition Support Services.~~

~~9. On-going evaluation after completion of the Wraparound Transition Plan may be provided based on individual needs to support the MemberClient and their family in connecting to any additional resources needed to prevent future Crisis or out of home placement.~~

~~8.508.101 USE OF RESTRAINTS~~

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~~A. The definitions contained at 12 CCR 2509-8; Section 7.714.1 (2019) are hereby incorporated by reference. The definition for "MemberClient Representative" in 12 CCR 2509-8, Section.7.714.1 is specifically excluded. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.~~

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B. Service Providers shall comply with the requirements for the use of Restraints in 12 CCR 2509-8, Sections 7.714.53 through 7.714.537, (2019) which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

C. All records of restraints shall be reviewed by a supervisor of the Service Provider within 24 hours of the incident. If it appears that the MemberClient has been restrained excessively, frequently in a short period of time, or frequently by the same staff member, the MemberClient's Service Plan must be reviewed.

D. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of restraints in Sections 8.608.2, 3, & 4 for MemberClients receiving Habilitation services age eighteen (18)- twenty (20).

8.508.102 RIGHTS MODIFICATIONS

A. Cruel and aversive therapy, or cruel and unusual discipline is prohibited.

B. Service Providers shall comply with the requirements for MemberClient Rights in 12 CCR 2509-8; Section 7.714.52 (2019) is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. Section 24-4-103(12.5) C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

C. Rights modifications are based on the specific assessed needs of the child or youth, not the convenience of the provider.

D. Rights modifications may only be imposed if the MemberClient poses a danger to self, Family, and/or the community.

E. The case manager is responsible for obtaining Informed Consent and other documentation supporting any rights modifications/limitations and must maintain these materials in their file as a part of the Service Plan.

F. Any rights modification must be supported by a specific assessed need and justified in the Service Plan. The following must be documented in the Service Plan:

1. Identification of a specific and individualized need.

2. Documentation of the positive interventions and supports used prior to any modifications Service Plan.

3. Documentation of less intrusive methods of meeting the MemberClient's needs that have been tried, and the outcome.

4. A description of the rights modification to be used that is directly proportionate to respond to the specific assessed need.

5. The collection and review of data used to measure the ongoing effectiveness of the modification.

6. Established time limits for periodic reviews, no less than every six (6) months, to determine if the modification is still necessary or if it can be terminated.

7. The Informed Consent of the Individual.

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8. An assurance that interventions and Support will cause no harm to the Individual.

G. Specialized Group Facilities, Foster Care Homes, Kinship Foster Care Home, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours), and Child Placement Agencies must also ensure compliance with the Colorado Department Human Services rules regarding the use of restrictive interventions at 12 CCR 2509-8.

H. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of rights modifications at § 8.604.3 and for MemberClients receiving Habilitation services age eighteen (18)- twenty (20).

[SECTION 8.508.103 AND 8.508.165 REMAIN UNCHANGED AND UNAFFECTED BY THIS RULEMAKING]

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8.508.165 TERMINATION OR DENIAL OF HCBS-CHRP MEDICAID PROVIDER AGREEMENTS

A. The Department may deny or terminate an HCBS-CHRP waiver Medicaid provider agreement in accordance with Section 8.076.5.

8.508.180 MEMBERCLIENT'S RIGHTS

A. Service Providers shall comply with the requirements for MemberClient's Rights in 12 CCR 2509-8; Section 7.714.31 (2019) which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to Section 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

B. Every MemberClient has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, gender identity, political affiliation, sexual orientation, financial status or disability.

C. Every MemberClient has the right to access age appropriate forms of communication including text, email, and social media.

D. No MemberClient, his/her Family members, Guardian or MemberClient Representative may be retaliated against in their receipt of services or supports as a result of attempts to advocate on their own behalf.

E. Each MemberClient receiving services has the right to read or have explained in each MemberClient's and Family's native language, any policies and/or procedures adopted by the Service Agency.

F. Host Homes and Service Providers contracting with Host Home Providers must comply with the procedural requirements regarding rights at § 8.604.2 for MemberClients receiving Habilitation services age eighteen (18)- twenty (20).

8.508.190 APPEALS

A. The CMACB shall provide a Long-Term Care notice of action form (LTC 803) to Applicants and MemberClients and their parent(s) or Guardian in accordance with section 8.057 when:

1. The Applicant is determined not to have a developmental delay or developmental disability,

2. The Applicant is determined eligible or ineligible for Long-Term Services and Supports (LTSS),

3. The Applicant is determined eligible or ineligible for placement on a waiting list for LTSS services,

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4. An Adverse Action occurs that affects the MemberClient's waiver enrollment status.

B. The CMACB shall appear and defend its decision at the Office of Administrative Courts.

C. The CCB shall notify the Case Management Agency in the MemberClient's Service Plan within one (1) business day of the Adverse Action.

D. The CMACB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business days of an Adverse Action that affects Medicaid financial eligibility.

E. The CMACB shall notify the applicant's parent or Guardian of an Adverse Action if the applicant or MemberClient is determined ineligible for any reason including if:

1. The MemberClient is detained or resides in a correctional facility for at least one day, and

2. The MemberClient enters an institute for mental health for a duration greater than thirty (30) days.

F. The CMA shall provide the Long-Term Care notice of action form to MemberClients in accordance with section 8.507 when:

1. An Adverse Action occurs that affects the MemberClient's waiver services, or

G. The CMA shall notify all providers in the MemberClient's Service Plan within one (1) business days of the Adverse Action.

1. The CMA shall notify the county Department of Human/Social Services income maintenance technician within ten (10) business days of an Adverse Action that may affect financial eligibility for HCBS waiver services.

H. The applicant or MemberClient shall be informed of an Adverse Action if the applicant or MemberClient is determined to be ineligible as set forth in the waiver- specific MemberClient eligibility criteria and the following:

1. The MemberClient cannot be served safely within the Cost Containment identified in the HCBS waiver,

2. The MemberClient is placed in an Institution for treatment for more than thirty (30) consecutive days,

3. The MemberClient is detained or resides in a correctional facility for at least one day, or

4. The MemberClient enters an institute for mental health for more than thirty (30) consecutive days.

I. The MemberClient shall be notified, pursuant to section 8.057.2. when the following results in an Adverse Action that does not relate to waiver MemberClient eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the Level of Care Evaluation and Determination

2. A Service Plan or waiver service exceeds the limits set forth in the federally approved waiver.

3. The MemberClient is being terminated from HCBS due to a failure to attend a Level of Care assessment appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

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4. The MemberClient is being terminated from HCBS due to a failure to attend a Service Plan appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

5. The MemberClient enrolls in a different LTSS program.

6. The MemberClient moves out of state. The MemberClient shall be discontinued effective the day after the date of the move.

a. A MemberClient who leaves the state on a temporary basis, with intent to return to Colorado, pursuant to Section 8.100.3.B.4, shall not be terminated unless one or more of the MemberClient eligibility criteria are no longer met.

J. If a MemberClient voluntarily withdraws from the waiver, the termination shall be effective the day after the date the s the request was made by the MemberClient

1. The case manager shall review with the MemberClient their decision to voluntarily withdraw from the waiver. The Case Manager shall not send a notice of action, upon confirmation of withdraw.

K. The CMA shall not send a Long-Term Care notice of action form when the basis for termination is death of the MemberClient but shall document the event in the MemberClient record. The date of action shall be the day after the date of death.

L. The CMA shall appear and defend its decision at the Office of Administrative Courts when the CMA has issued an Adverse Action.

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

~~8.509.10 GENERAL PROVISIONS~~

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~~8.509.11 LEGAL BASIS~~

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

~~B. All congregate facilities where any HCBS MemberClient resides must be in possession of a valid Assisted Living Residence license issued under Section 25-27-105, C.R.S., and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7.~~

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

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

~~1. Adult Day Services~~

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

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

~~4. Electronic Monitoring~~

~~5. Home Delivered Meals~~

~~6. Home Modification~~

~~7. Homemaker Services~~

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

~~9. Non-Medical Transportation~~

~~10. Peer Mentorship~~

~~11. Personal Care~~

~~12. Respite Care~~

~~13. Transition Setup~~

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

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

~~8.509.13 DEFINITIONS OF SERVICES~~

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~~A. Adult Day Services is defined at Section 8.491.~~

~~B. Alternative Care Services is defined at Section 8.495.1.~~

~~C. Consumer Directed Attendant Support Services (CDASS) is defined at Section 8.510.1.~~

~~D. Electronic Monitoring services is defined at Section 8.488.11.~~

~~E. Home Delivered Meals is defined at Section 8.553.1.~~

~~F. Home Modification is defined at Section 8.493.1.~~

~~G. Homemaker Services is defined at Section 8.490.1.~~

~~H. Life Skills Training (LST) is defined at Section 8.553.1.~~

~~I. Non-Medical Transportation is defined at Section 8.494.1.~~

~~J. Peer Mentorship is defined at Section 8.553.~~

~~K. Personal Care is defined at Section 8.500.94.B.12.~~

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

~~M. Transition Setup is defined at Section 8.553.~~

~~8.509.14 GENERAL DEFINITIONS~~

~~A. Assessment shall be defined as a MemberClient evaluation according to requirements at Section 8.390.1 DEFINITIONS.~~

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

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

~~D. Categorically Eligible, shall be defined in the HCBS-CMHS Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the MemberClient is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-CMHS as three hundred percent eligible persons, as defined at 8.509.14.S.~~

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

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

~~G. Continued Stay Review shall be defined as a Reassessment as defined in Section 8.390.1 and conducted as described at Section 8.402.60.~~

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

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I. Department shall be defined as the State Agency designated as the Single State Medicaid Agency for Colorado, or another state agency operating under the authority of a memorandum of understanding with the Single State Medicaid Agency.

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

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

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

M. Intake/Screening/Referral shall be as defined at Section 8.390.1(M) and as the initial contact with MemberClients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long-term care MemberClient assessment.

N. Level Ff Care Screen shall be defined as an assessment conducted in accordance with Section 8.401.16

O. Non-Diversion shall be defined as a MemberClient who was certified by the URC as meeting the Level of Care Screen and target group for the HCBS-CMHS program, but who did not receive HCBS-CMHS services for some other reason.

P. Person-Centered Support Plan shall be as defined in Section 8.390.1 DEFINITIONS.

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

R. Reassessment shall be as defined in Section 8.390.1 DEFINITIONS.

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

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

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

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

8.509.15 ELIGIBLE PERSONS

A. HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

MemberClients shall meet the eligibility criteria as specified in 9 CCR 2503-5, and the Section 8.100.

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~~2. Level of Care AND Target Group.~~

~~MemberClients who have been determined to meet the level of care AND target group criteria shall be determined by the Utilization Review Contractor (URC) as meeting the level of care eligibility for HCBS-CMHS. The URC shall only determine HCBS-CMHS eligibility for those MemberClients:~~

~~a. Determined to meet the target group definition, defined as a person experiencing a severe and persistent mental health need that requires assistance with one or more Activities of Daily Living (ADL);~~

~~i. A person experiencing a severe and persistent mental health need is defined as someone who:~~

~~1) Is 18 years of age or older with a severe and persistent mental health need; and~~

~~2) Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM -5); and~~

~~a) Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and~~

~~b) Has resulted in functional impairment which substantially interferes with or limits one or more major life activities.~~

~~ii. A severe and persistent mental health need does not include:~~

~~1) Intellectual or developmental disorders; or~~

~~2) Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.~~

~~b. Determined by a formal LOC Screen to require the level of care available in a nursing facility, according to Section 8.401.11-15; and~~

~~c. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.~~

~~3. Receiving Services~~

~~a. Only MemberClients who receive HCBS-CMHS services, or who have agreed to accept HCBS-CMHS services as soon as all other eligibility criteria have been met, are eligible for the HCBS-CMHS program.~~

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

~~c. Desire or need for home health services or other Medicaid services that are not HCBS-CMHS services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.~~

~~d. HCBS-CMHS MemberClients who have not received HCBS-CMHS services for thirty (30) days shall be discontinued from the program.~~

~~4. Institutional Status~~

~~a. MemberClients who are residents of nursing facilities or hospitals are not eligible for HCBS-CMHS services while residing in such institutions.~~

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

~~c. A MemberClient who is already an HCBS-CMHS recipient and who enters a nursing facility may not receive HCBS-CMHS services while in the nursing facility;~~

~~1) The case manager must terminate the MemberClient from the HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a LOC Eligibility Determination for the nursing facility placement, as verified by telephoning the URC.~~

~~2) A MemberClient receiving HCBS-CMHS services who enters a nursing facility for Respite Care as a service under the HCBS-CMHS program shall not be required to obtain a nursing facility LOC Screen and shall be continued as an HCBS-CMHS MemberClient in order to receive the HCBS-CMHS service of Respite Care in a nursing facility.~~

~~5. Cost-effectiveness~~

~~Only MemberClients who can be safely served within cost containment, as defined at Section 8.509.14 (I), are eligible for the HCBS-CMHS program. The equivalent cost of nursing facility care is calculated by the State, according to Section 8.509.19.~~

~~8.509.16 START DATE~~

~~The start date of eligibility for HCBS-CMHS services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which HCBS-CMHS services can be reimbursed shall be the LATER of any of the following:~~

~~A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.~~

~~B. Level of Care This date is determined by the official URC-assigned start date on the LOC Eligibility Determination.~~

~~C. Receiving Services This date shall be determined by the date on which the MemberClient signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept HCBS-CMHS services.~~

~~D. Institutional Status HCBS-CMHS eligibility cannot precede the date of discharge from the hospital or nursing facility.~~

[SECTION 8.509.17-18 REMAINS UNCHANGED AND IS UNAFFECTED THEY THIS RULE MAKING]

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~~8.509.19 STATE CALCULATION OF COST-CONTAINMENT AMOUNT~~

~~A. The State shall annually compute the equivalent monthly cost of nursing facility care according to Section 8.485.100.~~

~~B. LIMITATIONS ON PAYMENT TO FAMILY~~

~~1. With the exception of Consumer Directed Attendant Support Service, in no case shall any person be reimbursed to provide HCBS-CMHS services to his or her spouse.~~

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2. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-CMHS program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the MemberClient by virtue of blood, marriage, adoption or common law.

3. The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.

4. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

a. The maximum number of personal care units per annual certification for HCBS-CMHS shall be the equivalent of 444 hours. Family members must average at least 1.2164 hours of care per day (as indicated on the MemberClient's care plan) in order to receive the maximum reimbursement.

b. The maximum shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision and all other administrative costs.

c. If the certification period for HCBS-CMHS is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the MemberClient is receiving care by the average units per day for a full year (444/365=1.2164).

5. If two or more HCBS-CMHS MemberClients reside in the same household, family members may be reimbursed up to the maximum for each MemberClient if the services are not duplicative and are appropriate to meet the MemberClient's needs.

6. When HCBS-CMHS funds are utilized for reimbursement of personal care services provided by the MemberClient's family, the home care allowance cannot be used to reimburse the family.

7. Services other than personal care or Consumer Directed Attendant Support Services shall not be reimbursed with the HCBS-CMHS funds when provided by the MemberClient's family.

C. MEMBERCLIENT RIGHTS

1. The case manager shall inform MemberClients eligible for HCBS-CMHS in writing, of their right to choose between HCBS-CMHS services and nursing facility care; and

2. The case manager shall offer MemberClients eligible for HCBS-CMHS, the free choice of any and all available and qualified providers of appropriate services.

8.509.20 CASE MANAGEMENT AGENCIES

A. The requirement at Section 8.390 et. seq. shall apply to the case management agencies performing the case management functions of the HCBS-CMHS program.

8.509.21 CERTIFICATION

A. Case management agencies shall be certified, monitored and periodically recertified as required in Section 8.394 et. seq.

B. Case management agencies must have provider agreements with the Department that are specific to the HCBS-CMHS program.

8.509.22 REIMBURSEMENT

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Case management agencies shall be reimbursed for case management activities according to Section 8.392 et. seq.

8.509.30 CASE MANAGEMENT FUNCTIONS

8.509.31 NEW HCBS-CMHS MEMBERCLIENTS

A. INTAKE/SCREENING/REFERRAL

1. Case management agency staff shall complete a State-prescribed Intake form in accordance with the Single Entry Point Intake Procedures at Section 8.393.2 for each potential HCBS-CMHS Applicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the Applicant for purposes of establishing a start date. Additionally, at intake, MemberClients shall be offered an opportunity to identify a third party to receive MemberClient notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to MemberClients.

2. Case management agency staff shall verify the individual's current financial eligibility status or refer the MemberClient to the county department of social services of the MemberClient's county of residence for application. This verification shall include whether the Applicant is in a category of assistance that includes financial eligibility for long-term care.

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a Level of Care Eligibility Determination Screen and shall explain the reasons for the decision on the Intake form. The MemberClient shall be informed of the right to request an LOC Screen if the MemberClient disagrees with the case manager's decision.

4. If the case management agency staff has determined that a LOC Screen is needed, or if the MemberClient requests one a case manager shall be assigned to schedule the assessment.

B. ASSESSMENT

1. The SEP case manager shall complete the LOC Screen in accordance with Section .C-D

2. The URC/SEP case manager shall begin and complete the LOC Screen within ten (10) days of notification of MemberClient's need for assessment.

3. The SEP case manager shall complete the following activities for a LOC Screen:

a. Obtain all required information from the MemberClient's medical provider including information required for target group determination;

b. Determine the MemberClient's level of care needs during a face-to-face interview, preferably with the observation of the MemberClient in his or her residential setting. Upon Department approval, the assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or MemberClient (e.g. natural disaster, pandemic, etc.).;

c. Determine the ability and appropriateness of the MemberClient's caregiver, family, or others , to provide the MemberClient assistance in activities of daily living;

d. Determine the MemberClient's service needs, including the MemberClient's need for services not provided under HCBS-CMHS

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e. If the MemberClient is a resident of a nursing facility, determine the feasibility of deinstitutionalization;

f. Review service options based on the MemberClient's needs, the potential funding sources, and the availability of resources;

g. Explore the MemberClient's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;

h. View and document the current Assisted Living Residence license, if the MemberClient lives, or plans to live, in a congregate facility as defined at Section 8.509.14in order to assure compliance with the regulation at Section 5.509.11(B).

i. Determine and document MemberClient preferences in program selection;

j. Complete documentation on the LOC Screen.

k. To de-institutionalize a MemberClient who is in a nursing facility under payment by Medicaid, and with an existing nursing facility Level of Care Eligibility Determination with a completion date older than six (6) months, , the URC/SEP case manager shall complete a new LOC Screen and determine whether the Memberclient continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a Memberclient leaves a nursing facility, and no one has notified the URC/SEP agency of the Memberclient's intent to apply for HCBS-CMHS, the case manager must complete a new LOC Screen and the MemberClient shall be treated as an Applicant from the community rather than as a de-institutionalized MemberClient.

l. It is the URC/SEP case manager's responsibility to assess the behaviors of the MemberClient and assure that community placement is appropriate.

C. HCBS-CMHS DENIALS AND/OR DISCONTINUATIONS

1. If a MemberClient is determined, at any point in the level of care eligibility determination process, to be ineligible for HCBS-CMHS according to any of the requirements at Section 8.509.15, the case manager shall refer the MemberClient or the MemberClient's designated representative to other appropriate services. MemberClients who are denied HCBS-CMHS services shall be notified of denials and appeal rights as follows:

a. Financial Eligibility

The income maintenance technician at the county department of social services shall notify the Applicant of denial for reasons of financial eligibility and shall inform the Applicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.

b. Level of Care AND Target Group

The URC shall notify the Applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the Applicant of appeal rights in accordance with Section 8.057. The case manager shall not make judgments as to eligibility regarding level of care or target group and shall refer all Applicants who request a URC review to the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in

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accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.

c. Receiving Services

The case manager shall notify the Applicant of denial, on Department-prescribed form, when the case manager determines that the Applicant does not meet the HCBS-CMHS eligibility requirements at Section 8.509.15 and shall inform the Applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

d. Institutional Status

The case manager shall notify the Applicant of denial, on a Department-prescribed form, when the case manager determines that the Applicant does not meet the eligibility requirement at Section 8.509.15 and shall inform the Applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

e. Cost-effectiveness

The case manager shall notify the Applicant of denial, on Department-prescribed form, when the case manager determines that the Applicant does not meet the eligibility requirement 8.509.15 and shall inform the Applicant of appeal rights in accordance with Section 8.057, et.seq. The case manager shall also attend the appeal hearing to defend this denial action. If the Applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the Applicant, and the competency of the Applicant to choose to live in an unsafe situation. If the case manager determines that the Applicant will be unsafe with the amount of services available and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-CMHS eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the MemberClient's physician attesting to the MemberClient's mental competency status, and all other available information which will support the determination that the MemberClient is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the URC in regard to level of care and target group determination.

f. Waiver Cap

The case manager shall notify the Applicant of denial, on a Department-prescribed form, when the waiver cap limiting the number of MemberClients who may be served under the terms of the approved waiver has been reached.

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~~D. SERVICE PLANNING~~

~~1. Service Planning shall be defined in accordance with case planning at Section 8.393.2 and shall include, but not be limited to, the following tasks:~~

~~a. The identification and documentation of service plan goals and Member~~Client choices;

~~b. The identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, finding source, and services needed but not available;~~

~~c. Documentation of the Member~~Client's choice of HCBS-CMHS services, nursing home placement, or other services, including a physical or digitally signed statement of choice from the Member~~Client;~~

~~d. Documentation that the Member~~Client, was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the Member~~Client understands his/her right to change providers;~~

~~e. The formalization of the service plan agreement on a State-prescribed service plan form, including appropriate physical or digital signatures;~~

~~f. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the Member~~Client regarding service provision;

~~g. Referral to community resources as needed and development of resources for individual Member~~Clients if a resource is not available within the Member~~Client's community;~~

~~h. The explanation of complaint procedures to the Member~~Client.

~~2. The case manager shall meet the Member~~Client's needs, with consideration of the Member~~Client's choices, using the most cost-effective methods available.~~

[SECTION 8.509.31.E REMAINS UNCHANGED AND IS UNAFFECTED BY THIS RULEMAKING]

~~F. COST CONTAINMENT~~

~~The case manager shall determine whether the person can be served at or under the cost containment criteria of Section 8.509.14(I) for long-term care services for an individual recipient by using a state-prescribed Prior Authorization Request (PAR) form to:~~

~~1. Determine the maximum authorized costs for all HCBS-CMHS services for the period of time covered by the case plan and compute the average cost per day by dividing by the number of days in we case plan period; and~~

~~2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:~~

~~a. Enter (in the designated space on the PAR form) the average monthly cost of nursing facility care; and~~

~~b. Subtract from that amount the Member~~Client's gross monthly income: and

~~c. Subtract from that amount the Member~~Client's Home Care Allowance grant amount, if any: and

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d. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount which cannot be exceeded for the cost of HCBS services.

3. An individual MemberClient whose service needs exceed the amount allowed under the MemberClient's individual cost containment amount may choose to purchase additional services with personal income, but no MemberClient shall be required to do so.

G. PRIOR AUTHORIZATION REQUESTS

1. The case manager shall complete and submit a prior authorization request (PAR) for all HCBS-CMHS services to the state or its agent in a timely manner in accordance with the STATE PRIOR AUTHORIZATION OF SERVICES in Section 8.485.90..

2. If a PAR includes a request for home modification services, the PAR shall also include all documentation listed at Section 8.493, HOME MODIFICATION.

3. If a PAR is for an Alternative Care Facility MemberClient who is 300% eligible, the most recent state-prescribed MemberClient Payment form shall be included in the PAR. All medical and remedial care requested as deductions on the MemberClient Payment form must be listed on the long-terml Service Plan form.

4. The start date on the prior authorization request form shall never precede the start date of eligibility for HCBS-CMHS services, according to Section 8.509.16, START DATE.

5. The PAR shall not cover a period of time longer than the length of stay assigned by the URC.

6. A PAR does not have to be submitted for a non-diversion, as defined at 8.509.14(O).

7. If a PAR is returned to the case management agency for corrections, the corrected PAR must be returned to the State or its agent within thirty (30) calendar days after the case management agency receives the “Return to Provider” letter.

H. CASE MANAGEMENT AGENCY RESPONSIBILITY

1. The case management agency shall be financially responsible for any services which it authorized to be provided to the MemberClient, or which continue to be rendered by a provider due to the case management agency's failure to timely notify the provider that the MemberClient was no longer eligible for services, which did not receive approval by the state or its agent.

8.509.32 ONGOING HCBS-CMHS MEMBERCLIENTS

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS MemberClients shall be in accordance with Section 8.393.2. In addition, the case manager shall:

a. Contact each MemberClient quarterly, or more frequently, as determined by the MemberClient’s assessed needs. Contact may be at the MemberClient’s place of residence, by telephone, or other appropriate setting as determined by the MemberClient’s needs.

b. Review the LOC Screen and the PCSP with the Memberclient every six (6) months in person. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or MemberClient (e.g. natural disaster, pandemic, etc.).

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2. The case manager shall refer the MemberClient for mental health services taking into account MemberClient choice. The case manager shall coordinate case management activities for those MemberClients who are receiving mental health services from the Behavioral Health Organizations (BHO).

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

a. Review of the MemberClient's case plan and service agreements;

b. Contact with the MemberClient concerning whether services are being delivered according to the plan; and the MemberClient's satisfaction with services provided;

c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;

d. Contact with appropriate parties in the event any issues or complaints have been presented by the MemberClient or others;

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

f. Informal assessment of changes in MemberClient functioning, service effectiveness, service appropriateness, and service cost-effectiveness;

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

h. Referral to community resources, and arrangement for non-HCBS-CMHS services, as needed.

4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or mis-utilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

B. REVISIONS

1. SERVICES ADDED TO THE SERVICE PLAN

a. Whenever a change in the service plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the state or its agent.

1) The revision PAR shall include the revised Long-term Care plan form and the revised Prior Authorization Request form.

2) The revised service plan form shall list the services being revised and shall state the reason for the revision. Services on the revised service plan form, plus all services on the original service plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.

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3) The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.

b. If a revised PAR includes a new request for home modification services, the revised PAR shall also include all documentation listed at Section 8.493.

2. SERVICES DECREASED ON THE SERVICE PLAN

a. If services are decreased without the MemberClient's agreement according to Section 8.057.5, the case manager shall notify the MemberClient of the adverse action and of appeal rights, according to Section 8.057, et. seq.

C. REASSESSMENT

1. The case manager shall complete a level of care Reassessment of each HCBS-CMHS MemberClient before the end of the length of stay assigned by the URC at the Level of Care Eligibility Determination. The case manager shall initiate a Reassessment more frequently when warranted by significant changes that may affect HCBS-CMHS eligibility.

2. The case manager shall complete the Reassessment, utilizing the Department prescribed instrument.

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

a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long-term care benefits;

b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;

c. Evaluate continuing need for the HCBS-CMHS program, and clearly document reasons for continuing HCBS; or terminate the MemberClient's eligibility according to Section 8.509.32(E);

d. Ensure that all information needed from the medical provider for the LOC Screen is included.

e. Reassess the MemberClient's level of care status, according to the procedures in Section 8.509.31(B);

f. Review the PCSP, including verification of whether services have been delivered according to the PCSP, and write a new PCSP, according to procedures at Section 8.509.31(D);

g. Refer the MemberClient to community resources, as needed;

h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31(G). For MemberClients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the Level of Care Eligibility Determination. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the MemberClient and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Office of Administrative Courts to the MemberClient; or (c) a copy of the notice of a scheduled court date.

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Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed and shall not be accepted as a substitute for the Level of Care Eligibility Determination. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

D. TRANSFER PROCEDURES

1. When MemberClients move, cases shall be transferred according to the current statewide Mental Health Services Continuity of Care Policy.

2. INTERCOUNTY TRANSFERS shall be in accordance with Section 8.393.31.

3. INTERDISTRICT TRANSFERS shall be in accordance with Section 8.393.32.

E. TERMINATION

1. MemberClients shall be terminated from the HCBS-CMHS program whenever they no longer meet one or more of the eligibility requirements at Section 8.509.15. MemberClients shall also be terminated from the program if they die, move out of state or voluntarily withdraw from the program.

2. MemberClients who are terminated from HCBS-CMHS because they no longer meet one or more of the eligibility requirements at Section 8.509.15 shall be notified of the termination and their appeal rights as follows:

a. Financial Eligibility

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason.

b. Level of Care AND Target Group

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason.

c. Receiving Services

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason

d. Institutional Status

Procedures at Section 8.509.31(C) shall be followed for terminations for this reason. In the case of termination for extended hospitalization, the case manager shall send the termination notice on the thirtieth (30) day of hospitalization. The termination shall he effective at the end of the advance notice period. If the MemberClient returns home before the end of the advance notice period, the termination shall be rescinded.

e. Cost-effectiveness

Procedures at Section 8.509.31(C) shall be followed for terminations for this reason.

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3. When MemberClients are terminated from HCBS-CMHS for reasons not related to eligibility requirements at Section 8.509.31(C), the case manager shall follow the procedures below:

a. Death

MemberClients who die shall be terminated from the HCBS-CMHS program, effective upon the day after the date of death.

b. Moved out of State

MemberClients who move out of Colorado shall be terminated from the HCBS-CMHS program, effective upon the day after the date of the move. The case manager shall send the MemberClient a state-prescribed Advisement Letter advising the MemberClient that the case has been closed. MemberClients who leave the state on a temporary basis, with intent to return to Colorado, according to the Income Maintenance Staff Manual Section 1140.2, shall not be terminated from the HCBS-CMHS program unless one or more of the other eligibility criteria, as specified at Section 8.509.15 is no longer met.

c. Voluntary Withdrawal from the Program

MemberClients who voluntarily withdraw from the HCBS-CMHS program shall be terminated from the program, effective upon the day after the date on which the MemberClient either requests in writing to withdraw from the program, or the date on which the MemberClient enters a nursing facility. The case manager shall send the MemberClient a state-prescribed Advisement Letter advising the MemberClient that the case has been closed.

4. The case manager shall provide appropriate referrals to other community resources, as needed, upon termination.

5. The case manager shall immediately notify all providers on the case plan of any terminations.

6. If a case is terminated before an approved PAR has expired, the case manager shall submit, to the state or its agent, a copy of the current prior authorization request form, on which the end date is adjusted (and highlighted in some manner on the form); and the reason for termination shall be written on the form.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

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

1. The case manager shall inform the income maintenance technician of any and all changes in the MemberClient's participation in HCBS-CMHS and shall provide the technician with copies the Level of Care Eligibility Determination.

2. The case manager shall inform all Alternative Care Facility MemberClients of their obligation to pay the full and current state-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

3. If the MemberClient has an open service case file at the county department of social services, the case manager shall keep the MemberClient's caseworker informed of the MemberClient's status and shall participate in mutual staffing of the MemberClient's case.

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

5. Within five (5) working days of receipt, from the State or it; agent, of the approved Prior Authorization Request form, the case manager shall provide copies to all the HCBS-CMHS providers in the case plan.

6. The case manager shall notify the URC, on a form prescribed by the state of the outcome of all non-diversions, as defined at Section 8.509.14.

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

8. The case management agency shall notify the state of any MemberClient appeals which are initiated as a result of denials or terminations made by the case management agency.

B. CASE RECORDING/DOCUMENTATION

1. The case management agency shall maintain records on every individual for whom intake was conducted, including a copy of the intake form. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the case management agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.

2. The case record shall include:

a. Identifying information, including the state identification (Medicaid) number, and

b. All state-required forms; and

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

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

a. A separate case record shall be maintained for each MemberClient receiving services in the Home and Community-based Services for Community Mental Health Supports Program.

b. Documentation shall be legible;

c. Entries shall be written at the time of the activity or shortly thereafter,

d. Entries shall be dated according to the date of the activity, including the year;

e. Entries shall be made in permanent ink or digital signature;

f. The MemberClient shall be identified on every page;

g. The person making each entry shall be identified;

h. Entries shall be concise, but shall include all pertinent information;

i. All information regarding a MemberClient shall be kept together for easy access and review by case managers, supervisors, program monitors and auditors;

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

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k. All persons and agencies referenced in the documentation shall be identified by name and by relationship to the MemberClient;

l. All forms prescribed by the State shall be filled out by the case manager to be complete, correct and accurate.

m. If the individual is unable to sign a form requiring his/her signature because of a medical condition, a digital signature or any mark the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of guardian or other authorized representative will be accepted.

4. All records shall be kept for the period of time specified in the case management agency contract, and shall be made available to the state as specified in the contract.

8.509.40 HCBS-CMHS PROVIDERS

A. Any provider agency with a valid contract to provide HCBS-EBD services, according to Section 8.487, shall be deemed certified to provide the same services to HCBS-CMHS MemberClients.

[SECTION 8.509.50 REMAINS UNCHANGED AND IS UNAFFECTED BY THIS RULEMAKING]

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8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

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

B. Allocation means the funds determined by the Case Manager in collaboration with the MemberClient and made available by the Department through the Financial Management Service (FMS) vendor for Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option.

C. Assessment shall be as defined at Section 8.390.1.DEFINITIONS.

D. Attendant means the individual who meets qualifications in 8.510.8 who provides CDASS as described in 8.510.3 and is hired by the MemberClient or Authorized Representative through the contracted FMS vendor.

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

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

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

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

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~~delivery, evaluation of service effectiveness, and periodic Reassessment of MemberClient needs.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~W. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web site, MemberClient account statements, Case Manager contact, or FMS vendor contact.~~

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

~~Y. Training and Operations Vendor means the organization contracted by the Department to provide training and customer service for self-directed service delivery options to MemberClients, Authorized Representatives, and Case Managers.~~

~~8.510.2 ELIGIBILITY~~

~~8.510.2.A. To be eligible for the CDASS delivery option, the MemberClient shall meet the following eligibility criteria:~~

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

~~2. Meet HCBS waiver functional and financial eligibility requirements.~~

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

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

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

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

~~a. MemberClient training obligations~~

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

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

~~8.510.3 COVERED SERVICES~~

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

~~8.510.3.B. Services include:~~

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

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

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

~~b. Meal preparation;~~

~~c. Dishwashing;~~

~~d. Bed making;~~

~~e. Laundry;~~

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

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

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

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

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

~~d. Bladder/Bowel Care:~~

~~i) Assisting MemberClient to and from the bathroom;~~

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

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

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

~~v) Emptying ostomy bags;~~

~~vi) Perineal care.~~

~~e. Personal hygiene:~~

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

~~ii) Grooming;~~

~~iii) Shaving with an electric or safety razor;~~

~~iv) Combing and styling hair;~~

~~v) Filing and soaking nails;~~

~~vi) Basic oral hygiene and denture care.~~

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

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

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

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

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

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

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

~~k. Cleaning and basic maintenance of durable medical equipment.~~

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

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

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

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

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

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

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

~~ii) In the presence of communicable disease;~~

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

~~iv) Oral suctioning is required;~~

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

~~vi) MemberClient is at risk for choking and aspiration.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~iii) The use of a mechanical lift is needed.~~

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

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

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

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

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

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

~~ii) Care of external, indwelling and suprapubic catheters;~~

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

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

~~k. Respiratory care:~~

~~i) Postural drainage;~~

~~ii) Cupping;~~

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

~~iv) Suctioning mouth and/or nose;~~

~~v) Nebulizers;~~

~~vi) Ventilator and tracheostomy care;~~

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

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

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

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

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

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

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

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

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

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

ii) The MemberClient is unable to complete task independently

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

a. Homemaker services, as defined at Section 8.500.94.

b. Personal care services, as defined at Section 8.500.94.

c. Health maintenance activities as defined at Section 8.500.94.

8.510.4 EXCLUDED SERVICES

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

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

2. Following the death of MemberClient;

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

Companionship is not a covered CDASS service.

8.510.5 ATTENDANT SUPPORT MANAGEMENT PLAN

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

1. Needed Attendant support;

2. Plans for locating and hiring Attendants;

3. Plans for handling emergencies;

4. Assurances and plans regarding direction of CDASS Services, as described at 8.510.3 and 8.510.6, if applicable.

5. Plans for budget management within the MemberClient's Allocation.

6. Designation of an AR, if applicable.

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

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~~8.510.5.B. If the ASMP is disapproved by the Case Manager, the MemberClient or AR has the right to review the disapproval. The MemberClient or AR shall submit a written request to the CMA stating the reason for the review and justification of the proposed ASMP. The MemberClient's most recently approved ASMP shall remain in effect while the review is in process.~~

~~8.510.6 MEMBERCLIENT/AR RESPONSIBILITES~~

~~8.510.6.A. MemberClient/AR responsibilities for CDASS Management:~~

~~1. Complete training provided by the Training and Operations Vendor. MemberClients who cannot complete trainings shall designate an AR.~~

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

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

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

~~5. Recruit, hire and manage Attendants.~~

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

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

~~8. Terminate Attendants when necessary, including when an Attendant is not meeting the MemberClient's needs.~~

~~9. Operate as the Attendant's legal employer of record.~~

~~10. Complete necessary employment-related functions through the FMS vendor, including hiring and termination of Attendants and employer-related paperwork necessary to obtain an employer tax ID.~~

~~11. Ensure all Attendant employment documents have been completed and accepted by the FMS vendor prior to beginning Attendant services.~~

~~12. Follow all relevant laws and regulations applicable to the supervision of Attendants.~~

~~13. Explain the role of the FMS vendor to the Attendant.~~

~~14. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation. Services that exceed the MemberClient's monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the MemberClient or AR for reimbursement through the FMS vendor.~~

~~15. Authorize Attendant to perform services allowed through CDASS.~~

~~16. Ensure all Attendants required to utilize EVV are trained and complete EVV for services rendered. Timesheets shall be reviewed and reflect time worked that all required data points are captured to maintain compliance with 8.001.~~

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~~17. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and MemberClient/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS.~~

~~18. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement.~~

~~19. Authorize the FMS vendor to make any changes in the Attendant wages.~~

~~20. Understand that misrepresentations or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. MemberClient/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS vendor.~~

~~21. Completing and managing all paperwork and maintaining employment records.~~

~~21. Select an FMS vendor upon enrollment into CDASS.~~

~~8.510.6.B. MemberClient/AR responsibilities for Verification:~~

~~1. Sign and return a responsibilities acknowledgement form for activities listed in 8.510.6 to the Case Manager.~~

~~8.510.6.C. MemberClients utilizing CDASS have the following rights:~~

~~1. Right to receive training on managing CDASS.~~

~~2. Right to receive program materials in accessible format.~~

~~3. Right to receive advance Notification of changes to CDASS.~~

~~4. Right to participate in Department-sponsored opportunities for input.~~

~~5. MemberClients using CDASS have the right to transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.~~

~~6. A MemberClient/AR may request a reassessment if the MemberClient's level of service needs have changed.~~

~~7. A MemberClient/AR may revise the ASMP at any time with Case Manager approval.~~

~~8.510.7 AUTHORIZED REPRESENTATIVES (AR)~~

~~8.510.7.A. A person who has been designated as an AR shall submit an AR designation affidavit attesting that he or she:~~

~~1. Is least eighteen years of age;~~

~~2. Has known the eligible person for at least two years;~~

~~3. Has not been convicted of any crime involving exploitation, abuse, or assault on another person; and~~

~~4. Does not have a mental, emotional, or physical condition that could result in harm to the MemberClient.~~

~~8.510.7.B. CDASS MemberClients who require an AR may not serve as an AR for another CDASS MemberClient.~~

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~~8.510.7.C. An AR shall not receive reimbursement for CDASS AR services and shall not be reimbursed as an Attendant for the MemberClient they represent.~~

~~8.510.7.D. An AR must comply with all requirements contained in 8.510.6.~~

~~8.510.8 ATTENDANTS~~

~~8.510.8.A. Attendants shall be at least 16 years of age and demonstrate competency in caring for the MemberClient to the satisfaction of the MemberClient/AR.~~

~~1. Minor attendants will not be permitted to operate floor-based vertical powered patient/resident lift devices, ceiling-mounted vertical powered patient/resident lift devices, and powered sit-to-stand patient/resident lift devices (lifting devices).~~

~~8.510.8.B. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more MemberClients collectively.~~

~~8.510.8.C. An AR shall not be employed as an Attendant for the same MemberClient for whom they are an AR.~~

~~8.510.8.D. Attendants must be able to perform the tasks on the ASMP they are being reimbursed for and the MemberClient must have adequate Attendants to assure compliance with all tasks on the ASMP.~~

~~8.510.8.E. Attendant timesheets submitted for approval must be accurate and reflect time worked.~~

~~8.510.8.F. Attendants shall not misrepresent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse.~~

~~8.510.8.G. Attendants shall not have had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.~~

~~8.510.8.H. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the MemberClient/AR not to exceed the amount established by the Department. The FMS vendor shall make all payments from the MemberClient's Allocation under the direction of the MemberClient/AR within the limits established by the Department.~~

~~8.510.8.I. Attendants are not eligible for hire if their background check identifies a conviction of a crime that the Department has identified as a barrier crime that can create a health and safety risk to the MemberClient. A list of barrier crimes is available through the Training and Operations Vendor and FMS vendors.~~

~~8.510.8.J. Attendants may not participate in training provided by the Training and Operations Vendor. MemberClients may request to have their Attendant, or a person of their choice, present to assist them during the training based on their personal assistance needs. Attendants may not be present during the budgeting portion of the training.~~

~~8.510.9 FINANCIAL MANAGEMENT SERVICES (FMS)~~

~~8.510.9.A. FMS vendors shall be responsible for the following tasks:~~

~~1. Collect and process timesheets submitted by attendants within agreed-upon timeframes as identified in FMS vendor materials and websites.~~

~~2. Conduct payroll functions, including withholding employment-related taxes such as workers' compensation insurance, unemployment benefits, withholding of all federal and state taxes, and compliance with federal and state laws regarding overtime pay and minimum wage.~~

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3. Distribute paychecks in accordance with agreements made with MemberClient/AR and timelines established by the Colorado Department of Labor and Employment.

4. Submit authorized claims for CDASS provided to an eligible MemberClient.

5. Verify Attendants' citizenship status and maintain copies of I-9 documents.

6. Track and report utilization of MemberClient allocations.

7. Comply with Department regulations and the FMS vendor contract with the Department.

8.510.9.B. In addition to the requirements set forth at 8.510.9.A, the FMS vendor operating under the F/EA model shall be responsible for obtaining designation as a Fiscal/Employer Agent in accordance with Section 3504 of the Internal Revenue Code (2021). This statute is hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.510.10 SELECTION OF FMS VENDORS

8.510.10.A. The MemberClient/AR shall select an FMS vendor at the time of enrollment into CDASS from the vendors contracted with the Department.

8.510.10.B The MemberClient/AR may select a new FMS vendor during the designated open enrollment periods. The MemberClient/AR shall remain with the selected FMS vendor until the transition to the new FMS vendor is completed.

8.510.11 START OF SERVICES

8.510.11.A. The CDASS start date shall not occur until all of the requirements contained in 8.510.2, 8.510.5, 8.510.6 and 8.510.8 have been met.

8.510.11.B. The Case Manager shall approve the ASMP, establish a service period, submit a PAR and receive a PAR approval before a MemberClient is given a start date and can begin CDASS.

8.510.11.C. The FMS vendor shall process the Attendant's employment packet within the Department's prescribed timeframe and ensure the MemberClient has a minimum of two approved Attendants prior to starting CDASS. The MemberClient must maintain employment relationships with two Attendants while participating in CDASS.

8.510.11.D. The FMS vendor will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS vendor provides the MemberClient/AR with employee numbers and confirms Attendants' employment status.

8.510.11.E. If a MemberClient is transitioning from a hospital, nursing facility, or HCBS agency services, the Case Manager shall coordinate with the discharge coordinator to ensure that the MemberClient's discharge date and CDASS start date correspond.

8.510.12 SERVICE SUBSTITUTION

8.510.12.A. Once a start date has been established for CDASS, the Case Manager shall establish an end date and discontinue the MemberClient from any other Medicaid-funded Attendant support including Long-term Home Health, homemaker and personal care services effective as of the start date of CDASS.

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~~8.510.12.B. Case Managers shall not authorize PARs with concurrent payments for CDASS and other waiver service delivery options for Personal Care services, Homemaker services, and Health Maintenance Activities for the same MemberClient.~~

~~8.510.12.C. MemberClients may receive up to sixty days of Medicaid Acute Home Health services directly following acute episodes as defined by 8.523.11.K.1. CDASS service plans shall be modified to ensure no duplication of services.~~

~~8.510.12.D. MemberClients may receive Hospice services in conjunction with CDASS services. CDASS service plans shall be modified to ensure no duplication of services.~~

~~8.510.13 FAILURE TO MEET MEMBERCLIENT/AR RESPONSIBILITIES~~

~~8.510.13.A. If a MemberClient/AR fails to meet their CDASS responsibilities, the MemberClient may be terminated from CDASS. Prior to a MemberClient being terminated from CDASS the following steps shall be taken:~~

~~1. Mandatory re-training conducted by the contracted Training and Operations Vendor.~~

~~2. Required designation of an AR if one is not in place, or mandatory re-designation of an AR if one has already been assigned.~~

~~8.510.13.B. Actions requiring retraining, or appointment or change of an AR include any of the following:~~

~~1. The MemberClient/AR does not comply with CDASS program requirements including service exclusions.~~

~~2. The MemberClient/AR demonstrates an inability to manage Attendant support.~~

~~3. The MemberClient no longer meets program eligibility criteria due to deterioration in physical or cognitive health as determined by the MemberClient's physician, physician assistant, or advance practice nurse.~~

~~4. The MemberClient/AR spends the monthly Allocation in a manner causing premature depletion of funds without authorization from the Case Manager or reserved funds. The Case Manager will follow the service utilization protocol.~~

~~5. The MemberClient/AR exhibits Inappropriate Behavior as defined at 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor, or the FMS vendor.~~

~~6. The MemberClient/AR authorizes the Attendant to perform services while the MemberClient is in a nursing facility, hospital, a long-term care facility or while incarcerated.~~

~~8.510.14 IMMEDIATE INVOLUNTARY TERMINATION~~

~~8.510.14.A. MemberClients may be involuntarily terminated immediately from CDASS for the following reasons:~~

~~1. A MemberClient no longer meets program criteria due to deterioration in physical or cognitive health AND the MemberClient refuses to designate an AR to direct services.~~

~~2. The MemberClient/AR demonstrates a consistent pattern of overspending their monthly Allocation leading to the premature depletion of funds AND the Case Manager has determined that attempts using the service utilization protocol to assist the MemberClient/AR to resolve the overspending have failed.~~

~~3. The MemberClient/AR exhibits Inappropriate Behavior as defined at 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor or the FMS vendor, and the~~

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Department has determined that the Training and Operations Vendor has made attempts to assist the MemberClient/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

4. MemberClient/AR authorized the Attendant to perform services for a person other than the MemberClient, authorized services not available in CDASS, or allowed services to be performed while the MemberClient is in a hospital, nursing facility, a long-term care facility or while incarcerated and the Department has determined the Training and Operations Vendor has made adequate attempts to assist the MemberClient/AR in managing appropriate services through retraining.

5. Intentional submission of fraudulent CDASS documents or information to Case Managers, the Training and Operations Vendor, the Department, or the FMS vendor.

6. Instances of proven fraud, abuse, and/or theft in connection with the Colorado Medical Assistance program.

7. MemberClient/AR fails to complete retraining, appoint an AR, or remediate CDASS management per 8.510.13.A.

8. MemberClient/AR demonstrates a consistent pattern of non-compliance with EVV requirements determined by the EVV CDASS protocol.

a. Members experiencing FMS EVV systems issues must notify the FMS Vendor and/or Department of the issue within 5 business days. In the event of a confirmed FMS EVV system outage or failure impacting EVV submissions, the Department will not impose strikes or pursue termination, as appropriate, as outlined in the EVV Compliance protocol.

8.510.15 ENDING THE CDASS DELIVERY OPTION

8.510.15.A. If a MemberClient chooses to use an alternate care option or is terminated involuntarily, the MemberClient will be terminated from CDASS when the Case Manager has secured an adequate alternative to CDASS in the community.

8.510.15.B. In the event of discontinuation of or termination from CDASS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the MemberClient or AR with the reasons for termination, information about the MemberClient's rights to fair hearing, and appeal procedures. Once notice has been given for termination, the MemberClient or AR may contact the Case Manager for assistance in obtaining other home care services or additional benefits, if needed.

2. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS and begin alternate care services. Exceptions may be made to increase or decrease the thirty (30) day advance notice requirement when the Department has documented that there is danger to the MemberClient. The Case Manager shall notify the FMS vendor of the date on which the MemberClient is being terminated from CDASS.

8.510.15.C. MemberClients who are involuntarily terminated pursuant to 8.510.14.A 2., 8.510.14.A.4., 8.510.14.A.5, 8.510.14.A.6., and 8.510.14.A.7. may not be re-enrolled in CDASS as a service delivery option.

8.510.15.D. MemberClients who are involuntary terminated pursuant to 8.510.14.A.1. are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at 8.510.2.A.5. The MemberClient or AR must have successfully completed CDASS training prior to enrollment in CDASS.

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8.510.15.E. MemberClients who are involuntary terminated pursuant to 8.510.14.A.3 are eligible for enrollment in CDASS with the appointment of an AR. The MemberClient must meet all CDASS eligibility requirements with the AR completing CDASS training prior to enrollment in CDASS.

8.510.15.F. MemberClients who are involuntarily terminated pursuant to 8.510.14.A.8 are eligible for enrollment in CDASS 365 days from the date of termination. The MemberClient must meet all eligibility requirements and complete CDASS training prior to enrollment in CDASS.

8.510.16 CASE MANAGEMENT FUNCTIONS

8.510.16.A. The Case Manager shall review and approve the ASMP completed by the MemberClient/AR. The Case Manager shall notify the MemberClient/AR of ASMP approval and establish a service period and Allocation.

8.510.16.B. If the Case Manager determines that the ASMP is inadequate to meet the MemberClient's CDASS needs, the Case Manager shall work with the MemberClient/AR to complete a fully developed ASMP.

8.510.16.C. The Case Manager shall calculate the Allocation for each MemberClient who chooses CDASS as follows:

1. Calculate the number of personal care, homemaker, and health maintenance activities hours needed on a monthly basis using the Department's prescribed method. The needs determined for the Allocation should reflect the needs in the Department-approved assessment tool and the service plan. The Case Manager shall use the Department's established rate for personal care, homemaker, and health maintenance activities to determine the MemberClient's Allocation.

2. The Allocation should be determined using the Department's prescribed method at the MemberClient's initial CDASS enrollment and at reassessment. Service authorization will align with the MemberClient's need for services and adhere to all service authorization requirements and limitations established by the MemberClient's waiver program.

3. Allocations that exceed care in an institutional setting cannot be authorized by the Case Manager without Department approval. The Case Manager will follow the Department's over-cost containment process and receive authorization prior to authorizing a start date for Attendant services.

8.510.16.D. Prior to training or when an Allocation changes, the Case Manager shall provide written Notification of the Allocation to the MemberClient and the AR, if applicable.

8.510.16.E. A MemberClient or AR who believes the MemberClient needs a change in Attendant support, may request the Case Manager to perform a review of the CDASS Task Worksheet and Allocation for services. Review should be completed within five (5) business days.

1. If the review indicates that a change in Attendant support is justified, the following actions will be taken:

   a. The Case Manager shall provide notice of the Allocation change to the MemberClient/AR utilizing a long-term care notice of action form within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

   b. The Case Manager shall complete a PAR revision indicating the increase in CDASS Allocation using the Department's Medicaid Management Information System and

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FMS vendor system. PAR revisions shall be completed within five (5) business days of the Allocation determination.

c. The MemberClient/AR shall amend the ASMP and submit it to the Case Manager.

2. The Training and Operations Vendor is available to facilitate a review of services and provide mediation when there is a disagreement in the services authorized on the CDASS Task Worksheet.

3. The Case Manager will notify the MemberClient of CDASS Allocation approval or disapproval by providing a long-term care notice of action form to MemberClients within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

8.510.16.F. In approving an increase in the MemberClient's Allocation, the Case Manager shall consider all of the following:

1. Any deterioration in the MemberClient's functioning or change in availability of natural supports, meaning assistance provided to the MemberClient without the requirement or expectation of compensation.

2. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services.

3. The appropriate use and application of funds for CDASS services.

8.510.16.G. In reducing a MemberClient's Allocation, the Case Manager shall consider:

1. Improvement of functional condition or changes in the available natural supports.

2. Inaccuracies or misrepresentation in the MemberClient's previously reported condition or need for service.

3. The appropriate use and application of funds for CDASS services.

8.510.16.H. Case Managers shall cease payments for all existing Medicaid-funded personal care, homemaker, health maintenance activities and/or Long-Term Home Health as defined under the Home Health Program at Section §8.520 et seq. as of the MemberClient's CDASS start date.

8.510.16.I. For effective coordination, monitoring and evaluation of MemberClients receiving CDASS, the Case Manager shall:

1. Contact the CDASS MemberClient/AR once a month during the first three months to assess their CDASS management, their satisfaction with Attendants, and the quality of services received. Case Managers may refer MemberClients/ARs to the FMS vendor for assistance with payroll and to the Training and Operations Vendor for training needs, budgeting, and supports.

2. Contact the MemberClient/AR quarterly after the first three months to assess their implementation of Attendant services, CDASS management issues, quality of care, Allocation expenditures, and general satisfaction.

3. Contact the MemberClient/AR when a change in AR occurs and contact the MemberClient/AR once a month for three months after the change takes place.

4. Review monthly FMS vendor reports to monitor Allocation spending patterns and service utilization to ensure appropriate budgeting and follow up with the MemberClient/AR when discrepancies occur.

5. Utilize Department overspending protocol when needed to assist CDASS MemberClient/AR.

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6. Follow protocols established by the Department for case management activities.

8.510.16.J. Reassessment: The Case Manager will follow in-person and phone contact requirements based on the MemberClient's waiver program. Contacts shall include a review of care needs, the ASMP, and documentation from the physician, physician assistant, or advance practice nurse stating the MemberClient's ability to direct care.

8.510.16.K. Case Managers shall participate in training and consulting opportunities with the Department's contracted Training and Operations Vendor.

8.510.17 ATTENDANT REIMBURSEMENT

8.510.17.A. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the MemberClient/AR hiring the Attendant. The FMS vendor shall make all payments from the MemberClient's Allocation under the direction of the MemberClient/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified in the ASMP.

8.510.17.B. Attendant timesheets that exceed the MemberClient's monthly CDASS Allocation by 30% or more are not allowed and cannot be authorized by the MemberClient or AR for reimbursement through the FMS vendor.

8.510.17.C. Once the MemberClient's yearly Allocation is used, further payment will not be made by the FMS vendor, even if timesheets are submitted. Reimbursement to Attendants for services provided when a MemberClient is no longer eligible for CDASS or when the MemberClient's Allocation has been depleted are the responsibility of the MemberClient/AR.

8.510.17.D. Allocations that exceed the cost of providing services in a facility cannot be authorized by the Case Manager without Department approval.

8.510.18 REIMBURSEMENT TO FAMILY MEMBERS

8.510.18.A. Family Members/legal guardians may be employed by the MemberClient/AR to provide CDASS, subject to the conditions below.

8.510.18.B. The family member or legal guardian shall be employed by the MemberClient/AR and be supervised by the MemberClient/AR.

8.510.18.C. The Family Member and/or legal guardian being reimbursed as a personal care, homemaker, and/or health maintenance activities Attendant shall be reimbursed at an hourly rate with the following restrictions:

1. A Family Member and/or legal guardian shall not be reimbursed for more than forty (40) hours of CDASS in a seven-day period from 12:00 am on Sunday to 11:59 pm on Saturday.

2. Family Member wages shall be commensurate with the level of skill required for the task and should not deviate from that of a non-Family Member Attendant unless there is evidence of that the Family Member has a higher level of skill.

3. A member of the MemberClient's household may only be paid to furnish extraordinary care as determined by the Case Manager. Extraordinary care is determined by assessing whether the care to be provided exceeds the range of care that a Family Member would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the MemberClient and avoid institutionalization. Extraordinary care shall be documented on the service plan.

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~~8.510.18.D. A Member~~Client/AR ~~who chooses a Family Member as a care provider, shall document the choice on the ASMP.~~

[SECTION 8.511 REMAINS UNCHANGED AND IS UNAFFECTED BY THIS RULEMAKING]

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~~**8.515 HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH BRAIN INJURY (HCBS-BI)**~~

~~**8.515.1 LEGAL BASIS**~~

~~The Home and Community-based Services for Persons with Brain Injury (HCBS-BI) program is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. Section 1396a(a)(10)(B) (2018). This waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. Section 1396n (2018). This regulation is adopted pursuant to the authority in Section 25.5-1-303, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Sections 24-4-101 et seq., C.R.S. and the Home and Community-based Services for Persons with Brain Injury Act, Sections 25.5-6-701 et seq., C.R.S.~~

~~**8.515.2 HCBS-BI WAIVER SERVICES**~~

~~8.515.2.A SERVICES PROVIDED~~

~~1. Adult Day Services~~

~~2. Behavioral Programming and Education~~

~~3. Consumer Directed Attendant Support Services (CDASS)~~

~~4. Counseling Services~~

~~5. Day Treatment~~

~~6. Electronic Monitoring Services~~

~~7. Home Delivered Meals~~

~~8. Home Modification~~

~~9. Independent Living Skills Training (ILST)~~

~~10. Non-Medical Transportation Services~~

~~11. Peer Mentorship~~

~~12. Personal Care~~

~~13. Respite Care~~

~~14. Specialized Medical Equipment and Supplies~~

~~15. Substance Abuse Counseling~~

~~16. Supported Living~~

~~17. Transition Setup~~

~~18. Transitional Living Program~~

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8.515.2.B DEFINITIONS OF SERVICES

1. Adult Day Services means services as defined at Section 8.491.

2. Behavioral Programming and Education means services as defined at Section 8.516.40.

3. Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.

4. Counseling Services means services as defined at Section 8.516.50.

5. Day Treatment means services as defined at Section 8.515.80.

6. Electronic Monitoring Services means services as defined at Section 8.488.

7. Home Delivered Meals means services as defined at Section 8.553.

8. Home Modification means services as defined at Section 8.493.

9. Independent Living Skills Training (ILST) means services as defined at Section 8.516.10.

10. Non-Medical Transportation Services means services as defined at Section 8.494.

11. Peer Mentorship means services as defined at Section 8.553.

12. Personal Care means services as defined at Section 8.489.

13. Respite Care means services as defined at Section 8.516.70.

14. Specialized Medical Equipment and Supplies means services as defined at Section 8.515.50.

15. Substance Abuse Counseling means services as defined at Section 8.516.60.

16. Supported Living means services delivered by a community-based residential program that has been certified by the Department to provide the services defined at Section 25.5-6-703(8), C.R.S.

17. Transition Setup means services defined at Section 8.553.

18. Transitional Living Program means services as defined at Section 8.516.30.

8.515.3 GENERAL DEFINITIONS

Brain Injury means an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Nonpsychotic mental disorders due to brain damage; or

2. Anoxic brain damage; or

3. Compression of the brain; or

4. Toxic encephalopathy; or

5. Subarachnoid and/or intracerebral hemorrhage; or

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6. Occlusion and stenosis of precerebral arteries; or

7. Acute, but ill-defined cerebrovascular disease; or

8. Other and ill-defined cerebrovascular disease; or

9. Late effects of cerebrovascular disease; or

10. Fracture of the skull or face; or

11. Concussion resulting in an ongoing need for assistance with activities of daily living; or

12. Cerebral laceration and contusion; or

13. Subarachnoid, subdural, and extradural hemorrhage, following injury; or

14. Other unspecified intracranial hemorrhage following injury; or

15. Intracranial injury; or

16. Late effects of musculoskeletal and connective tissue injuries; or

17. Late effects of injuries to the nervous system; or

18. Unspecified injuries to the head resulting in ongoing need for assistance with activities of daily living.

Case Management Agency means the agency designated by the Department to provide the Single Entry Point Functions detailed at Section 8.393.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Person-Centered Support Plan means as defined in Section 8.390.1 DEFINITIONS.

8.515.4 SCOPE AND PURPOSE

The HCBS-BI program provides those services listed at Section 8.515.2.A to eligible individuals with brain injury that require long-term supports and services in order to remain in a community-based setting.

8.515.5 ELIGIBLE PERSONS

HCBS-BI program enrollment and services shall be offered only to individuals determined by the Department or its agent to have met all eligibility requirements in this Section 8.515.5.

8.515.5.A LEVEL OF CARE

Eligible individuals shall be determined by the Department or its agent to require one of the following levels of care:

1. Hospital Level of Care as evidenced by:

a. The individual shall have been:

i. Referred to the Case Management Agency while receiving inpatient care in an acute care or rehabilitation hospital for the treatment of the individual's brain injury; or

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ii. Determined by the Department or its agent to have require a hospital level of care as determined using the Department prescribed LOC Screen.

c. The individual shall require goal-oriented therapy with medical management by a physician; and

d. The individual cannot be therapeutically managed in a community-based setting without significant supervision and structure, specialized therapy, and support services.

2. Nursing Facility Level of Care as evidenced by all the following:

a. The individual shall have been determined by the Department or its agent to require nursing facility level of care as determined using the Department prescribed LOC Screen.

b. The individual shall require long-term support services at a level comparable to those services typically provided in a nursing facility.

8.515.5.B TARGET GROUP

Eligible individuals shall be determined by the Department or its agent to meet all the following target group criteria:

1. The individual shall have a diagnosis of Brain Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) and the LOC Screen.

2. Age Limit

a. Individuals enrolled in the Brain Injury waiver shall be aged 16 years and older and shall have sustained the brain injury prior to the age of 65.

8.515.5.C FINANCIAL ELIGIBILITY

Individuals must meet the financial requirements for long-term care medical assistance eligibility specified at Section 8.100.7.

8.515.5.D NEED FOR HCBS-BI SERVICES

1. Only MemberClients that currently receive HCBS-BI services, or that have agreed to accept HCBS-BI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-BI program.

a. Case management is provided as an administrative function, not an HCBS-BI service, and shall not be used to satisfy this requirement.

b. The desire or need for any Medicaid services other than HCBS-BI services, as listed at Section 8.515.1, shall not satisfy this eligibility requirement.

2. MemberClients that have not received an HCBS-BI service for a period greater than 30 consecutive days shall be discontinued from the program.

8.515.5.E EXCLUSIONS FROM ELIGIBILITY

1. Individuals who are residents of nursing facilities, hospitals, or other institutional settings are not eligible to receive HCBS-BI services.

2. HCBS-BI MemberClients that enter a nursing facility or hospital may not receive HCBS-BI services while admitted to the nursing facility or hospital.

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a. HCBS-BI MemberClients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-BI program.

b. HCBS-BI MemberClients entering a nursing facility for Respite Care as an HCBS-BI service shall not be discontinued from the HCBS-BI program.

8.515.5.F COST CONTAINMENT AND SERVICE ADEQUACY OF SERVICES

1. The MemberClient shall not be eligible for the HCBS-BI program if the case manager determines any of the following during the initial assessment and service planning process:

a. The MemberClient's needs cannot be met within the Individual Cost Containment Amount.

b. The MemberClient's needs are more extensive than HCBS-BI program services are able to support and/or that the MemberClient's health and safety cannot be assured in a community setting.

2. The MemberClient shall not be eligible for the HCBS-BI program at reassessment if the case manager determines the MemberClient's needs are more extensive than HCBS-BI program services are able to support and/or that the MemberClient's health and safety cannot be assured in a community setting.

3. If the case manager determines that the MemberClient's needs are more extensive than the HCBS-BI services are able to support and/or that the MemberClient's health and safety cannot be assured in a community setting, the case manager must document:

a. The results of an Adult Protective Services assessment;

b. A statement from the MemberClient's physician attesting to the MemberClient's mental competency status; and

c. Any other documentation necessary to support the determination

4. The MemberClient may be eligible for the HCBS-BI program at reassessment if the case manager determines that HCBS-BI program services are able to support the MemberClient's needs and the MemberClient's health and safety can be assured in a community setting.

a. If the case manager expects that the services required to support the MemberClient's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the MemberClient's request for services is appropriate and justifiable based on the MemberClient's condition.

i. The MemberClient may request of the case manager that existing services remain intact during this review process.

ii. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the MemberClient with:

1) The MemberClient's appeal rights pursuant to Section 8.057; and

2) Alternative options to meet the MemberClient's needs that may include, but are not limited to, nursing facility placement.

8.515.6 START DATE FOR SERVICES

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8.515.6.A. The start date of eligibility for HCBS-BI services shall not precede the date that all of the requirements in Section 8.515.5 have been met. The first date for which HCBS-BI services may be reimbursed shall be the later the following:

1. The date at which financial eligibility is effective.

2. The date at which the Department or its agent has made a Level of Care Determination that the MemberClient has met all level of care eligibility requirements at Section 8.515.5.

3. The date at which the MemberClient agrees to accept services and signs all necessary intake and Person-Centered Support Planning forms.

4. The date of discharge from an institutional setting.

8.515.7 PRIOR AUTHORIZATION OF SERVICES

8.515.7.A. All HCBS-BI services must be prior authorized by the Department or its agent.

8.515.7.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.515.7.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the MemberClient's documented medical condition and functional capacity;

2. Reasonable in amount, scope, frequency, and duration;

3. Not duplicative of the other services or supports included in the MemberClient's PCSP;

4. Not for services for which the MemberClient is receiving funds to purchase; and

5. Do not total more than 24 hours per day of care.

8.515.7.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

8.515.7.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-BI services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR.

1. Payment for HCBS-BI services is also conditional upon:

a. The MemberClient's eligibility for HCBS-BI services;

b. The provider's certification status; and

c. The submission of claims in accordance with proper billing procedures.

8.515.7.F. The prior authorization of services does not constitute an entitlement to those services. All services provided and reimbursed must be delivered in accordance with regulation and be necessary to meet the MemberClient's needs.

8.515.7.G. Services requested on the PAR shall be supported by information on the PCSP and the LOC Screen.

8.515.7.H. The PAR start date shall not precede the start date of HCBS-BI eligibility in accordance with Section 8.515.6.

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8.515.7.I. The PAR end date shall not exceed the end date of the HCBS-BI eligibility certification period.

8.515.8 WAITING LIST

8.515.7.A. Persons determined eligible for HCBS-BI services that cannot be served within the capacity limits of the HCBS-BI waiver shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the person's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.515.5 were determined to have been met and the HCBS-BI Program Administrator was notified.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the date of their waiting list placement.

8.515.9 CASE MANAGEMENT FUNCTIONS

The requirements at Section 8.393 shall apply to the Case Management Agencies performing the case management functions of the HCBS-BI program.

8.515.10 PROVIDER AGENCIES

HCBS-BI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

8.515.50 ASSISTIVE AND SPECIAL MEDICAL EQUIPMENT

A. DEFINITIONS

Specialized medical equipment and supplies includes devices controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Assistive Devices include equipment which meets one of the following criteria:

1. Is useful in augmenting an individual's ability to function at a higher level of independence and lessen the number of direct human service hours required to maintain independence;

2. Is necessary to ensure the health, welfare and safety of the individual;

3. Enables the individual to secure help in the event of an emergency;

4. Is used to provide reminders to the individual of medical appointments, treatments, or medication schedules; or

5. Is required because of the individual's illness impairment or disability, as documented on the screening assessment form and the plan of can.

B. INCLUSIONS

1. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

2. Items which are not of direct medical or remedial benefit to the recipient are excluded.

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3. Assistive devices to augment cognitive processes, "cognitive-orthotics" or memory prostheses are included in this service area. Examples of cognitive orthotic devices include informational data bases, spell checkers, text outlining programs, timing devices, security systems, car finders, sounding devices, cuing watches, telememo watches, paging systems, electronic monitoring, tape recorders, electronic checkbooks, electronic medication monitors, and memory telephone.

C. CERTIFICATION REQUIREMENTS

Certification standards refer to both the supplier of equipment as well as the actual product or equipment itself.

1. All items shall meet applicable standards of manufacture, design and installation.

2. All equipment materials or appliances used as pan of monitoring systems shall carry a UL (Underwriter's Laboratory) number or an equivalent standard.

3. All telecommunications equipment shall be FCC registered.

4. All equipment materials, or appliances shall be installed by properly trained individuals, and the installer shall train the MemberClient in the use of the device.

5. All equipment, materials or appliances shall be tested fir proper functioning at the time of installation and at periodic intervals thereafter by a properly trained individual.

6. Any malfunction shall be promptly repaired by a properly trained technician supplied at the provider agency's expense. Equipment shall be replaced when necessary, including buttons and batteries.

7. Assistive equipment providers shall send written information to each MemberClient's case manager about the item, how it works, and how it should be maintained.

D. REIMBURSEMENT METHOD FOR ASSISTTVE DEVICES

Reimbursement for assistive devices will be on a per unit basis. If assistive devices are to be used primarily in a vocational application, devices should be funded through the Division of Vocational Rehabilitation with secondary funding from Medicaid.

8.515.70 ADULT DAY SERVICES

A. DEFINITIONS

1. Adult Day Services means both health and social services furnished on a regularly scheduled basis in an Adult Day Services center two or more hours per day, one or more days per week to ensure the optimal functioning of the Memberclient Services are directed towards recreation and socialization as well as maintaining a safe and supportive environment. A participant can receive either Center-Based ADS, Non-Center-Based ADS, or a combination of Center-Based ADS and Non-Center-Based ADS within the same week.

a. Adult Day Services provider means a non-institutional entity that conforms to requirements for maintenance model.

b. Center-Based Adult Day Services are services provided in a certified ADS Center.

c. Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where participants can engage in activities and community life, either in-person or through virtual means.

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Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for participants to engage in activities, with their community, and connect to staff and other ADS participants virtually or over the phone, only if a participant does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services. .

e. Maintenance Model means services in health monitoring and individual and group therapeutic and psychological activities which serve as an alternative to long-term nursing home care.

2. Adult Day Services include:

a. Daily monitoring to assure that Memberclients are maintaining personal hygiene and participating in age appropriate social activities as prescribed; and assisting with activities prescribed; and assisting with activities of daily living (e.g., eating, dressing).

b. Emergency services including whiten procedures to meet medical crises.

c. Assistance in the development of self-care capabilities personal hygiene, and social support services.

d. Provision of nutritional needs appropriate to the hours in which the Memberclient is served. Nutrition services are not required during the delivery of Telehealth ADS.

e. Nursing services as necessary to supervise medication regimen of trained medication aides and carry out any of the services listed as SKILLED CARE in SECTION 8.489.30.

f. Social and recreational services as prescribed to meet the Memberclient's needs.

g. Documentation specifically stating the types of services and monitoring that were provided when services are provided via Telehealth, ensuring the integrity of the service provided and the benefit that service provides the participant.

B. CERTIFICATION STANDARDS

All Adult Day Service providers shall conform to all of the following Departmental standards

1. All providers must conform to all established departmental standards in the general certification standards section.

2. All providers of Adult Day Services shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The Adult Day Service Center shall provide a clean environment, free of obstacle; that could pose a hazard to clientMember health and safety.

4. Adult Day Service Centers shall provide lockers or a safe place for Memberclients' personal items.

5. Adult Day Service Centers shall provide recreational areas and activities appropriate to the number and needs of the recipients.

6. Adult Day Service Centers shall have drinking facilities located within easy access to Memberclients.

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7. Adult Day Service Centers shall provide eating and resting areas consistent with the number and needs of the Memberclients being served.

8. Adult Day Service Centers shall provide easily accessible toilet facilities, hand washing facilities and paper towel dispensers.

9. The center shall be accessible to Memberclients with supportive devices for ambulation or who an in wheelchairs.

C. RECORDS AND INFORMATION

Adult Day Service providers shall keep such records and information necessary to document the services provided to Memberclients receiving Adult Day Services. Medical Information Records shall include but not be limited to:

1. Medications the memberclient is taking and whether they are being self-administered.

2. Special dietary needs, if any.

3. Restrictions on activities identified by physician in the case plan.

D. STAFFING

All Adult Day Service providers shall have staff who have been trained in current cardiopulmonary resuscitation, seizure prophylaxis and control and brain injury. Adequate staff shall available at all times to ensure:

1. Supervision of memberclients at all times during the operating hours of the program.

2. Immediate response to emergency situations to assure the welfare of memberclients.

3. Provision of prescribed recreational and social activities.

4. Provision of administrative, recreational, social and supportive functions of the Adult Day Services Center.

E. POLICIES

The Adult Day Service provider shall have a written policy relevant to the operation of the Adult Day Services. Such policy shall include but not be limited to statements describing:

1. Admission criteria that qualify memberclients to be appropriately served by the provider.

2. Interview procedures conducted for qualified memberclients and/or family members prior to admission to the provider.

3. The meals and nourishments that will be provided, including special diets, at Center-Based ADS.

4. The hours that the meclimberents will be served by the provider and days of the week services will be available.

5. The personal items participants may bring with them to the center.

6. A written signed contract to be drawn up between the memberclient or responsible party and the Center outlining rules and responsibilities of the provider and of the memberclient. Each party of the contract will have a copy.

7. A statement of the center's policy for providing drop-in care or day respite.

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~~F. REIMBURSEMENT METHOD FOR ADULT DAY SERVICES~~

~~1. Reimbursement information for BI ADS is outlined in Section 8.491.5.B.~~

~~F. EXCLUSIONS~~

~~1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS and therefore are not reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.~~

~~8.515.80 DAY TREATMENT~~

~~A. DEFINITION~~

~~Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the recipient lives.~~

~~B. PROGRAM COMPONENTS, POLICIES AND PROCEDURES~~

~~1. Treatment plans are coordinated by a comprehensive interdisciplinary team which includes the recipient and his/her family and provides for consolidation of services in one location.~~

~~2. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, case management, and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan.~~

~~3. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statue.~~

~~4. The provider shall network with all allied medical professionals and other community-based resource providers.~~

~~5. Services include social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management).~~

~~6. Crisis situations with family, Member~~Client or staff shall be addressed through counseling and referral to appropriate professionals.

~~7. Behavioral programs shall contain specific guidelines on treatment parameters and methods.~~

~~8. There shall be regular contact and meetings with the Member~~Clients and their families to discuss treatment plan progress and revision.

~~9. Discharge planning will include the development of a plan which considers safety, environmental modification to support individual function, education of the family and caregiver, recommendations for the future, and referral to additional community resources.~~

~~10. Each entity must have a process, verified in writing, by which a Member~~Client is made aware of the process for filing a grievance.

~~11. Complaints by the Member~~Client or family are handled within a 24-hour period from the time of complaint by at least telephone contact.

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12. Transportation between therapeutic tasks in the community shall be included in the per diem cost of day treatment.

13. There shall be an inform and consent mechanism by which the MemberClient, family medical proxy or substitute decision maker is made aware of the inherent risks associated with community-based rehabilitation programs. Examples of such risks might include a greater likelihood of falling accidents, traffic hazards and access to drugs or alcohol.

C. HUMAN RIGHTS

Every person receiving HCBS-BI services has the following rights:

1. Every person shall mutually develop and sign their treatment plan.

2. Every person has the right to enjoy freedom of thought, conscience, and religion.

3. Every person has the right to live in a clean, safe environment.

4. Every person has the right to have his or her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his or her life.

5. Every person has the right to be free from physical abuse and inhumane treatment.

6. Every person has the right to be protected from all forms of sexual exploitation.

7. Every person has the right to access necessary medical care which is adequate and appropriate to their condition.

8. Every person has the right to communicate with significant others.

9. Every person has the right to reasonable enjoyment of privacy in personal conversations.

10. Every person has the right to have access to telephones, both to make and receive calls in privacy.

11. Every person has the right to have frequent and convenient opportunities to meet with visitors.

12. Every person has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status, or disability.

13. Every person who acts as his own legal guardian has the right to accept treatment of his/her own free will.

14. Nothing in this pan shall be construed to prohibit necessary assistance as appropriate, to those individuals who may require such assistance to exercise their rights.

15. Every person has the right to be free of physical restraint unless physical intervention is necessary to prevent such body movement that is likely to result in imminent injury to self or others, and only if alternative techniques have failed. Mechanical restraints are not allowed.

D. DOCUMENTATION

1. Intake information shall include a complete neuropsychological assessment and all pertinent medical documentation from inpatient and outpatient therapy and social history to identify key treatment components and communicate the functional implications of treatment goals.

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2. Initial treatment plan development and evaluations will occur within a two-week period following admission.

3. Treatment plan goals and objectives shall reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and treatment plans will be reviewed and modified as appropriate.

5. Progress notes will be kept to document specific treatment modalities rendered by date and signed by the therapist providing the service.

E. CERTIFICATION STANDARDS

1. Directors of day treatment programs shall have professional licensure in a health-related program in combination with at least 2 years of experience in head trauma rehabilitation programming.

2. All providers shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The agency shall provide a clean environment, free of obstacles that could pose a hazard to MemberClient health and safety.

4. Agencies shall provide lockers or a safe place for MemberClients' personal items.

5. Day treatment centers shall provide age appropriate activities and provide eating and resting areas consistent with the number and needs of the MemberClients being served.

6. The center shall be accessible according to guidelines established by the Americans with Disabilities Act.

7. Personnel shall have training appropriate to the medical needs of the MemberClients served including seizure management training, CPR certification, non-violent crisis intervention, and personal care standards according to SECTION-PERSONAL CARE 8.489.40.

F. REIMBURSEMENT

Day treatment services will be paid on a per diem basis at a rate to be determined by the Department In order for a provider to be paid for a day of treatment, a MemberClient must have attended and received therapeutic intervention which is substantiated by case file notes signed by the rendering therapist

8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.A DEFINITIONS

1. Activities of Daily Living (ADLs) mean basic self-care activities, including mobility, bathing, toileting, dressing, eating, transferring, support for memory and cognition, and behavioral supervision.

2. Assistance means the use of manual methods to guide or assist with the initiation or completion of voluntary movement or functioning of an individual's body through the use of physical contact by others, except for the purpose of providing physical restraint.

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3. Assistive Technology Devices means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

4. Authorized Representative means an individual designated by the MemberClient or the legal guardian, if appropriate, who has the judgment and ability to assist the MemberClient in acquiring and utilizing supports and services.

5. Behavioral Management and Education means services as defined in § 8.516.40.A, and Inclusions as defined at § 8.516.40.B, provided as an individually developed intervention designed to decrease/control the MemberClient's severe maladaptive behaviors which, if not modified, will interfere with the MemberClient's ability to remain integrated in the community.

6. Case Management Agency (CMA) means an agency within a designated service area where an Applicant or MemberClient can obtain Case Management services. CMAs include Single Entry Points (SEPs), Community Centered Boards (CCBs), and private case management agencies.

7. Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual MemberClient's fLevel of Care Eligibility Determination for the Home and Community-based Services – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and Person-Centered Support Plan for the MemberClient, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic Reassessment of such MemberClient's needs.

8. Critical Incident means an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a MemberClient that could have, or has had, a negative impact on the mental and/or physical well-being of a MemberClient in the short or long-term. A critical incident includes accidents, a suspicion of, or actual abuse, neglect, or exploitation, and criminal activity.

9. Department means the Department of Health Care Policy and Financing.

10. Health Maintenance Activities means those routine and repetitive health-related tasks which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These activities include, but are not limited to, catheter irrigation, administration of medication, enemas, suppositories, and wound care.

11. Independent Living Skills Training means services designed and directed toward the development and maintenance of the MemberClient's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

12. Instrumental Activities of Daily Living (IADLs) means activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework and communication.

13. Interdisciplinary Team means a group of people responsible for the implementation of a MemberClient's individualized care plan, which includes the MemberClient receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by the MemberClient's needs and preferences, who are assembled in a cooperative manner to develop or review the person-centered care plan.

14. Personal Care Services includes providing assistance with eating, bathing, dressing, personal hygiene or other activities of daily living. When specified in the service plan, Personal Care Services may also include housekeeping chores such as bed making, dusting, and vacuuming. Housekeeping assistance must be incidental to the care furnished

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or essential to the health and welfare of the individual rather than for the benefit of the individual's family.

15. Person-Centered Support Plan is as defined in Secgtion 8.390.1 DEFINITIONS.

16. Protective Oversight is defined as monitoring and guidance of a MemberClient to assure their health, safety, and well-being. Protective oversight includes but is not limited to: monitoring the MemberClient while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the MemberClient to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the MemberClient's choice and ability to travel and engage independently in the wider community and providing guidance on safe behavior while outside the Supportive Living Program.

17. Room and Board is defined as a comprehensive set of services that include lodging, routine or basic supplies for comfortable living, and nutritional and healthy meals and food for the MemberClient, all of which are provided by the Supportive Living Program provider, and are not included in the per diem.

18. Supportive Living Program (SLP) certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to the Department after the SLP provider has met all licensing requirements found in 6 C.C.R. 1011-1; Chapter 2, and either Chapter 7 or 26, in addition to all requirements in § 8.515.85.

8.515.85.B MEMBERCLIENT ELIGIBILITY

1. SLP services are available to individuals who meet all of the following requirements:

a. MemberClients are determined to meet level of care eligibility for HCBS-BI waiver by a certified case management agency as outlined in Section 8.515.5.

b. MemberClients are enrolled in the HCBS-BI waiver; and

c. MemberClients require the specialized services provided under the SLP as determined by assessed need.

8.515.85.C SUPPORTIVE LIVING PROGRAM INCLUSIONS

1. SLP services consist of structured services designed to provide:

a. Assessment;

b. Protective Oversight and supervision;

c. Behavioral Management and Education;

d. Independent Living Skills Training in a group or individualized setting to support:

i. Interpersonal and social skill development;

ii. Improved household management skills; and

iii. Other skills necessary to support maximum independence, such as financial management, household maintenance, recreational activities and outings, and other skills related to fostering independence;

e. Community Participation;

f. Transportation between therapeutic activities in the community;

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g. Activities of Daily Living (ADLs);

h. Personal Care and Homemaker services; and

i. Health Maintenance Activities.

2. Person-Centered Care Planning

SLP providers must comply with the Person-Centered Care Planning process. Providers must work with CMAs to ensure coordination of a MemberClient's Person-Centered Care Plan. Additionally, SLP providers must provide the following actionable plans for all HCBS-BI waiver MemberClients, updated every six (6) months:

a. Transition Planning; and

b. Goal Planning.

These elements of a Person-Centered Care Plan are intended to ensure the MemberClient actively engages in his or her care and activities, as is able to transition to any other type of setting or service at any given time.

3. Exclusions

The following are not included as components of the SLP:

a. Room and board; and

b. Additional services which are available as a State Plan benefit or other HCBS-BI waiver service. Examples include, but are not limited to physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, long-term home health, and private duty nursing.

8.515.85.D PROVIDER LICENSING AND CERTIFICATION REQUIREMENTS

1. To be certified as an SLP provider, the entity seeking certification must be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. 7, except as provided below.

a. Subject to Department approval, providers that have been in continuous operation at the same address prior to 1987 may continue to furnish SLP services under a Home Care Agency (HCA) license pursuant to 6 CCR 1011-1, Ch. 26 instead of the ALR license.

i. Providers furnishing SLP services under a Department-approved exception are required to comply with this § 8.515.85, regardless of licensure type.

ii. Providers furnishing SLP services under a Department-approved exception are required to comply with the medication administration requirements pursuant to both the HCA licensure requirements found at 6 CCR 1011-1, Chapters 7 and 26, and Section 25-1.5-301 through 304, C.R.S. 6 CCR 1011-1, Ch. 7, Section 14, (2018) is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103 (12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety,

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available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. In addition to the requirements of § 8.515.85.D.1, SLP providers must also receive SLP Certification from CDPHE. CDPHE issues or renews a Certification when the provider is in full compliance with the requirements set out in these regulations. Certification is valid for three years from the date of issuance unless CDPHE revokes, suspends, or takes other disciplinary action against the licensee, or the certification is voluntarily relinquished by the provider.

3. No Certification shall be issued or renewed by CDPHE if the owner, applicant, or administrator of the SLP has been convicted of a felony or of a misdemeanor, which felony or misdemeanor involves moral turpitude or involves conduct that the Department determines could pose a risk to the health, safety, or welfare of residents of the assisted living residence.

8.515.85.E PROVIDER RESPONSIBILITIES

SLP providers must follow all person-centered planning initiatives undertaken by the State to ensure MemberClient choice.

8.515.85.F HCBS PROGRAM CRITERIA

1. In accordance with 42 C.F.R. § 441.530, Home and Community-based settings must:

a. Be integrated in and support full access to the greater community;

b. Be selected by the MemberClient from among setting options;

c. Ensure MemberClient rights of privacy, dignity, and respect, and freedom from coercion and restraint;

d. Optimize individual initiative, autonomy, and independence in making life choices;

e. Facilitate MemberClient choice regarding services and supports, and who provides them;

f. Be a specific, physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity;

g. Ensure privacy in the MemberClient's unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;

h. Ensure that MemberClients have the freedom and support to control their own schedules and activities, and have access to food at any time;

i. Ensure each MemberClient has the right to receive and send packages. No MemberClient's outgoing packages shall be opened, delayed, held, or censored by any person;

j. Ensure each MemberClient has the right to receive and send sealed, unopened correspondence. No MemberClient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person;

i. Enable MemberClients to have visitors of their choosing at any time; and

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j. Be physically accessible.

2. Exceptions

The Department may grant exceptions to HCBS Program Criteria listed in § 8.515.85.F.1, a through h, when reasonable, as follows:

a. Requirements of program criteria may be modified if supported by a specific assessed need and justified in the person-centered care plan. The following requirements must be documented in the person-centered care plan:

i. Identify a specific and individualized assessed need.

ii. Document the positive interventions and supports used prior to any modifications to the person-centered care plan.

iii. Document less intrusive methods of meeting the need that have been tried but did not work.

iv. Include a clear description of the modification that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

viii. Include an assurance that interventions and supports will cause no harm to the individual.

b. HCBS Program Criteria under 8.515.85.F.1.b and e:

i. When a MemberClient chooses to receive HCBS in a provider-owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the MemberClient cannot choose an alternative provider to deliver services that are included in the bundled rate.

ii. For any services that are not included in the bundled rate, the MemberClient may choose any qualified provider, including the provider who controls or owns the setting, if the provider offers the service separate from the bundle.

c. HCBS Program Criteria under 8.515.85.F.1.c:

When a MemberClient needs assistance with challenging behavior, including a MemberClient whose behavior is dangerous to himself, herself, or others, or when the MemberClient engages in behavior that results in significant property destruction, the SLP must create detailed service and support plans that describe how to appropriately address these behaviors.

d. HCBS Program Criteria under 8.515.85.F.1.g:

Requirements for a lockable entrance door may be modified if supported by a specific assessed need and justified in the person-centered service plan.

8.515.85.G STAFFING

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1. The SLP provider shall ensure sufficient staffing levels to meet the needs of MemberClients.

2. The operator, staff, and volunteers who provide direct MemberClient care or protective oversight must be trained in precautions and emergency procedures, including first aid, to ensure the safety of the memberclientele.

3. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 6, 7, and 8, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5) C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

4. Within one month of the date of hire, the SLP provider shall provide adequate training for staff on each of the following topics:

   a. Crisis prevention;

   b. Identifying and dealing with difficult situations;

   c. Cultural competency;

   d. Infection control; and

   e. Grievance and complaint procedures.

5. Prior to providing direct care, the SLP provider shall provide to the operator, staff, and volunteers an orientation to the location in which the program operates, and adequate training on person-centered care planning.

6. All staff training shall be documented. Copies of person-centered care plan training and related documentation must be submitted to the Department upon request. Prior to any subsequent change in the training curriculum, the provider must submit copies to the Department for review and approval.

7. In addition to the requirements of 6 CCR 1011-1 Ch. 7 , the Department requires that the program director shall have an advanced degree in a health or human service related profession plus two years of experience providing direct services to persons with a brain injury. A bachelor's or nursing degree with three years of similar experience, or a combination of education and experience shall be an acceptable substitute.

8. The provider shall employ or contract for behavioral services and skill training services according to MemberClient needs.

9. The SLP shall ensure that provision of services is not dependent upon the use of MemberClients to perform staff functions. Volunteers may be utilized in the home but shall not be included in the provider's staffing plan in lieu of employees.

10. The SLP provider shall maintain written personnel policies and shall provide a copy of these policies to each staff member upon employment. The administrator or designee shall explain such policies during the initial staff orientation period.

11. The SLP provider shall conduct a criminal background check through the Colorado Bureau of Investigation for all staff, prospective staff, and volunteers. The provider shall not employ any person convicted of an offense that could pose a risk to the health, safety, and welfare of MemberClients. The provider shall bear all costs related to obtaining a criminal background check.

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8.515.85.H MEMBERCLIENT RIGHTS AND PROPERTY

1. MemberClients shall have all rights stated in § 8.515.85.F.1.

2. Any provider that chooses to handle MemberClient funds and property must maintain policies and practices for management of MemberClient funds and property that are consistent with those at 6 CCR 1011-1, Ch. 7, Section 11.10.

3. Upon MemberClient request, a MemberClient shall be entitled to receive, and the provider shall promptly deliver, available money or funds held in trust.

8.515.85.I FIRE SAFETY AND EMERGENCY PROCEDURES

1. Applicants for initial provider Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by DFPC.

a. The Department may grant an exception to this provision for a provider qualified under § 8.515.85.D.1.c, if the provider holds a current certificate of compliance from the local fire authority.

3. Providers shall develop written emergency plans and procedures for fire, serious illness, severe weather, disruption of essential utility services, and missing persons for each MemberClient. Emergency and evacuation procedures shall be consistent with any relevant local and state fire and life safety codes and the provisions set forth in 6 CCR 1011-1 Ch. 7, § 10.

4. Within three (3) days of scheduled work or commencement of volunteer service, the program shall provide adequate training for staff in emergency and fire escape plan procedures.

5. SLP providers must train all staff and MemberClients on emergency plans and procedures at intervals throughout the year. Providers shall conduct fire drills at least once every six (6) months, during the evening and overnight hours while MemberClients are sleeping. All such practices and training shall be documented and reviewed every six (6) months. Such documentation shall include any difficulties encountered and any needed adaptations to the plan. Such adaptations shall be implemented immediately upon identification.

8.515.85.J ENVIRONMENTAL AND MAINTENANCE REQUIREMENTS

1. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 15,16, 17, and 19, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. The interior and exterior environment of the SLP residence shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 20, 21, 22, 23, and 24, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

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3. MemberClients shall be allowed free use of all common living areas within the residence, with due regard for privacy, personal possessions, and safety of MemberClients.

4. SLP providers shall develop and implement procedures for the following:

a. Handling of soiled linen and clothing;

b. Storing personal care items;

c. General cleaning to minimize the spread of pathogenic organisms; and

d. Keeping the home free from offensive odors and accumulations of dirt and garbage.

5. The SLP provider shall ensure that each MemberClient is furnished with his or her own personal hygiene and care items. These items are to be considered basic in meeting an individual's needs for hygiene and remaining healthy. Any additional items may be selected and purchased by the MemberClient at their discretion.

6. There shall be adequate bathroom facilities for individuals to access without undue waiting or burden.

7. Each MemberClient shall have access to telephones, both to make and to receive calls in privacy.

8.515.85.K COMPLAINTS AND GRIEVANCES

Each MemberClient will have the right to voice grievances and recommend changes in policies and services to both the Department and/or the SLP provider. Complaints and grievances made to the Department shall be made in accordance with the grievance and appeal process in § 8.209.

8.515.85.M RECORDS

1. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Section 18, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. Supportive Living Providers shall develop policies and procedures to secure MemberClient information against potential identity theft. Confidentiality of medical records shall be maintained in compliance with 45 C.F.R. § 160.101, et seq.

3. All medical records for adults (persons eighteen (18) years of age or older) shall be retained for no less than six (6) years after the last date of service or discharge from the SLP. All medical records for minors shall be retained after the last date of service or discharge from the SLP for the period of minority plus six (6) years.

8.515.85.N REIMBURSEMENT

1. SLP services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.

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2. The methodology for calculating the per diem rate shall be based on a weighted average of MemberClient acuity scores.

3. The Department shall establish a maximum allowable room and board charge for MemberClients in the SLP. Increases in payment shall be permitted in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises grant amounts.

a. Room and board shall not be a benefit of HCBS-BI residential services. MemberClients shall be responsible for room and board in an amount not to exceed the Department-established rate.

[SECION 8.515.85.O REMAINS UNCHANGED AND UNAFFECTED BY THIS RULEMAKING]

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8.516.10 INDEPENDENT LIVING SKILLS TRAINING

A. DEFINITIONS

1. Independent Living Skills Training (ILST) means services designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community. ILST may be provided in the MemberClient's residence, in the community, or in a group living situation.

2. ILST program service plans are plans that describe the ILST services necessary to enable the MemberClient to independently sustain himself/herself physically, emotionally, and economically in the community. This plan is developed with the MemberClient and the provider.

3. ILST Trainers are individuals trained in accordance with guidelines listed below tasked with providing the service inclusions to the program participant.

4. Person-Centered Care Plan is a plan of care created by a process that is driven by the individual and may also include people chosen by the individual, as well as the appropriate health care professional and the designated independent living ILST trainer(s). It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents MemberClient choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the MemberClient needs to function safely in the community. This plan is developed by the MemberClient with the case management agency.

B. INCLUSIONS

1. Reimbursable services are limited to the assessment, training, maintenance, supervision, assistance, or continued supports of the following skills:

a. Self-care, including but not limited to basic personal hygiene;

b. Medication supervision and reminders;

c. Household management;

d. Time management skills training;

e. Safety awareness skill development and training;

f. Task completion skill development and training;

g. Communication skill building;

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h. Interpersonal skill development;

i. Socialization, including but not limited to acquiring and developing appropriate social norms, values, and skills;

j. Recreation, including leisure and community integration activities;

k. Sensory motor skill development;

l. Benefits coordination, including activities related to the coordination of Medicaid services;

m. Resource coordination, including activities related to coordination of community transportation, community meetings, neighborhood resources, and other available public and private resources;

n. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting.

2. All Independent Living Skills Training shall be documented in the person-centered care plan. Reimbursement is limited to services described in the person-centered care plan.

C. PROVIDER CERTIFICATION STANDARDS

1. Provider agencies must have valid licensure and certification as well as appropriate professional oversight.

a. Agencies seeking to provide ILST services must have a valid Home Care Agency Class A or B license or an Assisted Living Residency license and Transitional Living Program provider certification from the Department of Public Health and Environment.

b. Agencies must employ an ILST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, brain injury, and a degree within a relevant field.

i. This coordinator must review ILST program service plans to ensure MemberClient plan is designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

c. Any component of the ILST plan that may contain activities outside the scope of the ILST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the MemberClient. These professionals must hold licenses with no limitations in one of the following professions:

i. Occupational Therapist;

ii. Physical Therapist;

iii. Registered Nurse;

iv. Speech Language Pathologist;

v. Psychologist;

vi. Neuropsychologist;

vii. Medical Doctor;

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viii. Licensed Clinical Social Worker;

ix. Licensed Professional Counselor.

d. Professionals providing components of the ILST plan may include individuals who are members of agency staff, contracted staff, or external licensed and certified professionals who are fully aware of duties conducted by ILST trainers.

e. All ILST service plans containing any professional activity must be reviewed and authorized at least every 6 months, or as needed, by professionals responsible for oversight as referenced in 8.516.10.C.1.c.i-ix.

2. ILST trainers must meet one of the following education, experience, or certification requirements:

a. Licensed health care professionals with experience in providing functionally based assessments and skills training for individuals with disabilities; or

b. Individuals with a bachelor's degree and one year of experience working with individuals with disabilities; or

c. Individuals with an associate degree in a social service or human relations area and two years of experience working with individuals with disabilities; or

d. Individuals currently enrolled in a degree program directly related to but not limited to special education, occupational therapy, therapeutic recreation, and/or teaching with at least 3 years of experience providing services similar to ILST services; or

e. Individuals with 4 years direct care experience teaching or working with individuals with a brain injury or other cognitive disability either in a home setting, hospital setting, or rehabilitation setting.

3. The agency shall administer a series of training programs to all ILST trainers.

a. Prior to delivery of and reimbursement for any services, ILST trainers must complete the following trainings:

i. Person-centered care approaches; and

ii. HIPAA and MemberClient confidentiality; and

iii. Basics of brain injury including at a minimum;

1. Basic neurophysiology; and

2. Impact of a brain injury on an individual; and

3. Epidemiology of brain injury; and

4. Common physical, behavioral, and cognitive impairments and interactions strategies; and

5. Best practices in brain injury recovery; and

6. Screening for a history of brain injury.

iv. On-the-job coaching by an incumbent ILST trainer; and

v. Basic safety and de-escalation techniques; and

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vi. Training on community and public resource availability; and

vii. Understanding of current brain injury recovery guidelines; and

viii. First aid.

b. ILST trainers must also receive ongoing training, required annually, in the following areas:

i. Cultural awareness; and

ii. Updates on brain injury recovery guidelines; and

iii. Updates on resource availability.

D. REIMBURSEMENT

1. ILST shall be reimbursed according to the number of units billed, with one unit equal to 15 minutes of service. Payment and billing may not include travel time to and from the memberclient's residence.

8.516.30 TRANSITIONAL LIVING

A. DEFINITIONS

1. Transitional living means programs, which occur outside of the MemberClient's residence, designed to improve the MemberClient's ability to live in the community by provision of 24-hour services, support and supervision.

2. Program services include but are not limited to assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household.

3. Extraordinary therapy needs mean, for purposes of this program, a MemberClient who requires more than three hours per day of any combination of therapeutic disciplines. This includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

B. INCLUSIONS

1. All services must be documented in an approved plan of care and be prior authorized by the Department.

2. MemberClients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs.

3. MemberClients must require available paraprofessional nursing assistance on a 24-hour basis due to dependence in activities of daily living, locomotion, or cognition.

4. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a MemberClient requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for the Transitional Living Program service for a MemberClient must be documented and authorized individually by the Department.

C. EXCLUSIONS

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1. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges.

2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.

3. Room and board charges are not a billable component of transitional living services.

4. Items of personal need or comfort shall be paid out of money set aside from the ClientMember's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program.

5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the Department.

D. CERTIFICATION STANDARDS

Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-27-104.

1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs.

2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in the following sections entitled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS.

3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards.

4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis.

5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. MemberClients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

2. MemberClients, families, medical proxies, or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

3. Understanding that MemberClients of transitional living programs frequently experience behavior which may be a danger to himself/herself or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a MemberClient who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.

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4. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve MemberClients for whom they lack adequate resources to ensure safety of program participants and staff.

5. Upon entry into the program, discharge planning shall begin with the MemberClient and family. Transitional living programs shall work with the MemberClient and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services.

6. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

7. During daytime hours, the ratio of staff to MemberClients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.

8. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Department.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service-related profession plus three years of experience providing direct services to individuals with brain injury. A bachelor's degree with five years of experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.

2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the MemberClient. These staff members will have successfully completed a training program of at least 40 hours duration.

3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.

4. The operator, staff, and volunteers who provide direct MemberClient care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from impatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two-week period following admission.

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3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.

5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

6. All transitional services must utilize licensed psychologists win two years of experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the MemberClient and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.

7. Programs shall have a process verified in writing by which a MemberClient is made aware of the process for filing a grievance. Complaints by the MemberClient or family shall be handled via telephone or direct contact with the MemberClient or family.

8. Customer satisfaction surveys will be regularly performed and reviewed.

9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.

10. MemberClient safety in the community will be assessed: safety status and recommendations will be documented.

11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.

2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the acuity-based per diem reimbursement rate established by the Department.

Providers shall not charge a Medicaid participant more than the Department's annually established room and board rate.

All transitional living services shall be prior authorized through submission to the Department. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond a duration of 180 days must be reauthorized with treatment plan justification and shall be submitted through the reconsideration process established by the Department.

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8.516.40 BEHAVIORAL PROGRAMMING

A. DEFINITION

Behavioral programming and education is an individually developed intervention designed to decrease/control the MemberClient's severe maladaptive behaviors which, if not modified, will interfere with the individuals ability to remain integrated in the community.

B. INCLUSIONS

1. Programs should consist of a comprehensive assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the person's environment.

2. Behavioral programs may be provided in the community or in the MemberClient's residence unless the residence is a transitional living center which provides behavioral intervention as a treatment component

3. All behavioral programming must be documented in the plan of care and reauthorized after 30 units of service with the Brain Injury Program Coordinator.

C. CERTIFICATION STANDARDS

1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a health care professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters level Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of behavioral management concepts.

2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with brain injury if their work experience does not include at least one year of same.

D. REIMBURSEMENT

Behavioral programming must be documented on the MemberClient's care plan and prior authorized through the State Brain Injury Program Coordinator. Behavioral programming services will be paid on an hourly basis as established by the Department

8.516.50 COUNSELING

A. DEFINITIONS

Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries.

B. INCLUSIONS

1. Counseling is available to the program participant's family in conjunction with the MemberClient if they: a) have a significant role in supporting the MemberClient or b) live with or provide care to the MemberClient. "Family" includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the waiver participant.

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2. Services may be provided in the waiver participant's residence, in community settings, or in the provider's office.

3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.

4. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department as directed by certification standards listed below.

5. Family training/counseling must be carried out for the direct benefit of the MemberClient of the HCBS-BI program.

6. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the plan of care and shall include updates as may be necessary to safely maintain the individual at home.

7. Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

1. Family training is not available to individuals who are employed to care for the recipient.

D. CERTIFICATION STANDARDS

1. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker. Certified Rehabilitation Counselor. Licensed Professional Counselor, or Licensed Clinical Psychologist.

2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years of experience in providing counseling to individuals with brain injury and their families.

3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling, Individual Counseling, and Group Counseling.

8.516.60 SUBSTANCE ABUSE COUNSELING

A. DEFINITION

Substance abuse programs are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the water participant which, if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

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B. INCLUSIONS

1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program

2. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver participant, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons if directly involved in the support system of the MemberClient, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager.

3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall he submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

Inpatient treatment is not a covered benefit.

D. CERTIFICATION STANDARDS

1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing.

2. Programs must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury.

3. Counselors should be certified at the Certified Addiction Counselor II level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any individual with a brain injury or their family members. A recommended training curriculum will include a three-day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present). Individual Counseling, and Group Counseling.

8.516.70 RESPITE CARE

A. DEFINITIONS

1. Respite care means services provided to an eligible MemberClient on a short-term basis because of the absence or need for relief of those persons normally providing the care.

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2. Respite care provider means a Class I nursing facility, an alternative care facility or an employee of a certified personal care agency which meets the certification standards for respite care specified below.

B. INCLUSIONS

1. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite MemberClient, as ordered by the physician.

C. RESTRICTIONS

1. An individual MemberClient shall be authorized for no more than a cumulative total of thirty (30) days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home and in a nursing facility.

A. A mix of delivery options is allowable if the aggregate amount of services is below thirty (30) days, or 720 hours, of respite care.

1. In home respite is limited to no more than eight (8) hours per day.

2. Nursing facility respite billed on a per diem.

2. Only those portions of the facility that are Medicaid certified for nursing facility services may be utilized for respite MemberClients.

D. CERTIFICATION STANDARDS AND PROCEDURES

1. Respite care standards and procedures for nursing facilities are as follows:

A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

B. The nursing facility does not have to maintain or hold open separately designated beds for respite MemberClients but may accept respite MemberClients on a bed available basis.

C. For each HCBS-BI respite MemberClient, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the MemberClient. The chart must identify the MemberClient as a respite MemberClient. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

D. An admission to a nursing facility under HCBS-BI respite does not require a new ULTC-100.2, a PASARR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

E. The nursing facility shall have written policies and procedures available to staff regarding respite care MemberClients. Such policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care MemberClients.

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F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite MemberClient's entry into the facility.

3. Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

E. REIMBURSEMENT

1. Respite care reimbursement to nursing facilities shall be as follows:

A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-BI claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four-hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

2. Respite care reimbursement to alternative care facilities shall be as follows:

A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-BI claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four-hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

3. Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

4. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI services shall not be reimbursed during the respite stay.

5. There shall be no reimbursement provided under this section for respite care in uncertified, congregate facilities.

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~~8.517 HOME AND COMMUNITY-BASED SERVICES FOR THE COMPLEMENTARY AND INTEGRATIVE HEALTH WAIVER~~

~~8.517.1 HCBS-CIH WAIVER SERVICES~~

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~~8.517.1.A SERVICES PROVIDED~~

~~1. Acupuncture (CIHS)~~

~~2. Adult Day Services~~

~~3. Chiropractic (CIHS)~~

~~4. Consumer Directed Attendant Support Services (CDASS)~~

~~5. Electronic Monitoring~~

~~6. Home Delivered Meals~~

~~7. Home Modification~~

~~8. Homemaker Services~~

~~9. In-Home Support Services~~

~~10. Life Skills Training (LST)~~

~~11. Massage Therapy (CIHS)~~

~~12. Non-Medical Transportation~~

~~13. Peer Mentorship~~

~~14. Personal Care Services~~

~~15. Respite Care~~

~~16. Transition Setup~~

~~8.517.1.B DEFINITIONS OF SERVICES~~

~~1. Acupuncture (CIHS) means services as defined at Section 8.517.2.A.~~

~~2. Adult Day Services means services as defined at Section 8.491.~~

~~3. Chiropractic (CIHS) means services as defined at Section 8.517.2.B.~~

~~4. Complementary and Integrative Health Services (CIHS) means services as defined at Section 8.517.B.E.~~

~~5. Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.~~

~~6. Electronic Monitoring means services as defined at Section 8.488.~~

~~7. Home Delivered Meals means services as defined at Section 8.553.~~

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~~8. Home Modification means services as defined at Section 8.493.~~

~~9. Homemaker Services means services as defined at Section 8.490.~~

~~10. In-Home Support Services means services as defined at Section 8.552.~~

~~11. Life Skills Training (LST) means services as defined at Section 8.553.~~

~~12. Massage Therapy (CIHS) means services as defined at Section 8.517.2.H.~~

~~13. Non-Medical Transportation means services as defined at Section 8.494.~~

~~14. Peer Mentorship means services as defined at Section 8.553.~~

~~15. Personal Care Services means services as defined at Section 8.489.~~

~~16. Respite Care means services as defined at Section 8.492.~~

~~17. Transition Setup means services as defined at Section 8.553.~~

~~8.517.2 GENERAL DEFINITIONS~~

~~A. Acupuncture (CIHS) means the insertion of needles and/or manual, mechanical, thermal, electrical, and electromagnetic treatment to stimulate specific anatomical tissues for the promotion, maintenance and restoration of health and prevention of disease both physiological and psychological. During an acupuncture treatment, dietary advice and therapeutic exercises may be recommended in support of the treatment.~~

~~B. Chiropractic (CIHS) means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting and/or improving alignment, neurological function, and other musculoskeletal problems. During a chiropractic treatment, nutrition, exercise, and rehabilitative therapies may be recommended in support of the adjustment.~~

~~C. Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.~~

~~D. Complementary and Integrative Health Provider means an individual or agency certified annually by the Department to have met the certification standards listed at Section 8.517.11.~~

~~E. Complementary and Integrative Health Services (CIHS) means Acupuncture, Chiropractic, and Massage Therapy.~~

~~F. Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.~~

~~G. Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.~~

~~H. Massage Therapy (CIHS) means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.~~

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~~8.517.3 LEGAL BASIS~~

~~The Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CIH program is also authorized under state law at C.R.S. section 25.5-6-1301 et seq. – as amended.~~

~~8.517.4 SCOPE AND PURPOSE~~

~~8.517.4.A. The Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver provides assistance to individuals living with a qualifying condition of a spinal cord injury, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability for independent ambulation directly resulting from one of these conditions that require long-term supports and services in order to remain in a community setting.~~

~~8.517.4.B. The HCBS-CIH waiver provides an opportunity to study the effectiveness of Complementary and Integrative Health Services and the impact the provision of these service may have on the utilization of other HCBS-CIH waiver and/or acute care services.~~

~~8.517.4.C. An independent evaluation shall be conducted no later than January 1, 2025 to determine the effectiveness of the Complementary and Integrative Health Services.~~

~~8.517.5 MEMBERCLIENT ELIGIBILITY~~

~~8.517.5.A. ELIGIBLE PERSONS~~

~~Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services shall be offered only to individuals who meet all of the following eligibility requirements:~~

~~1. Individuals shall be aged 18 years or older.~~

~~2. Individuals shall have a qualifying condition of a spinal cord injury (traumatic or nontraumatic), multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability for independent ambulation directly resulting from one of these conditions as defined by broad diagnoses related to each condition within the most current version of the International Classification of Diseases (ICD) at the time of assessment.~~

~~3. Individuals must have been determined to have an inability for independent ambulation resulting from the qualifying condition as identified by the case manager through the assessment process. The inability for independent ambulation means:~~

~~a. The individual does not walk, and requires use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own, OR;~~

~~b. The individual does walk, but requires use of a walker or cane in all settings, whether or not they can use the walker or cane safely, on their own, OR;~~

~~c. The individual does walk but requires "touch" or "stand-by" assistance to ambulate safely in all settings.~~

~~8.517.5.B FINANCIAL ELIGIBILITY~~

~~Individuals must meet the financial eligibility requirements specified at Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.~~

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~~8.517.5.C LEVEL OF CARE CRITERIA~~

~~Individuals shall require long-term support services at a level of care comparable to services typically provided in a nursing facility or hospital.~~

~~8.517.5.D NEED FOR HOME AND COMMUNITY-BASED SERVICES FOR COMPLEMENTARY AND INTEGRATIVE HEALTH (HCBS-CIH) WAIVER SERVICES~~

~~1. Only individuals that currently receive Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services, or that have agreed to accept HCBS-CIH services as soon as all other eligibility criteria have been met, are eligible for the HCBS-CIH waiver.~~

~~a. Case management is not a HCBS-CIH service and shall not be used to satisfy this requirement.~~

~~b. The desire or need for any Medicaid services other than HCBS-CIH waiver services, as listed at Section 8.517.1, shall not satisfy this eligibility requirement.~~

~~2. Individuals that have not received at least one (1) HCBS-CIH waiver service for a period greater than 30 consecutive days shall be discontinued from the waiver.~~

~~8.517.5.E EXCLUSIONS~~

~~1. Individuals who are residents of nursing facilities or hospitals are not eligible to receive Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services.~~

~~2. HCBS-CIH MemberClients that enter a nursing facility or hospital may not receive HCBS-CIH waiver services while admitted to the nursing facility or hospital.~~

~~a. HCBS-CIH MemberClients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-CIH program.~~

~~b. HCBS-SCI MemberClients entering a nursing facility for Respite Care as an HCBS-CIH service shall not be discontinued from the HCBS-CIH program.~~

~~8.517.5.F COST CONTAINMENT AND SERVICE ADEQUACY~~

~~1. Individuals shall not be eligible for the Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver if the case manager determines any of the following during the initial assessment and service planning process:~~

~~a. The individual's needs cannot be met within the Individual Cost Containment Amount.~~

~~b. The individual's needs are more extensive than HCBS-CIH waiver services can support and/or that the individual's health and safety cannot be assured in a community setting.~~

~~2. Individuals shall not be eligible for the HCBS-SCI waiver at reassessment if the case manager determines the individual's needs are more extensive than HCBS-CIH waiver services are able to support and/or that the individual's health and safety cannot be assured in a community setting.~~

~~3. Individuals may be eligible for the HCBS-CIH waiver at reassessment if the case manager determines that HCBS-CIH waiver services are able to support the individual's needs and the individual's health and safety can be assured in a community setting.~~

~~a. If the case manager expects that the services required to support the individual's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the~~

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~~support plan to determine if the individual's request for services is appropriate and justifiable based on the individual's condition.~~

~~i) Individuals may request of the case manager that existing services remain intact during this review process.~~

~~ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:~~

~~1) Long-Term Care Notice of Action Form (LTC-803), informing the MemberClient of the denial and providing the MemberClient's appeal rights pursuant to Section 8.057; and~~

~~2) Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.~~

~~8.517.6 WAITING LIST~~

~~1. The number of MemberClients who may be served through the Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver during a fiscal year may be limited by the federally approved waiver.~~

~~2. Individuals determined eligible for the HCBS-CIH waiver who cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.~~

~~3. The waiting list shall be maintained by the Department.~~

~~4. The case manager shall ensure the individual meets all eligibility criteria as set forth at Section 8.517.5 prior to notifying the Department to place the individual on the waiting list.~~

~~5. The date the case manager determines an individual has met all eligibility requirements as set forth at Section 8.517.5 is the date the Department will use for the individual's placement on the waiting list.~~

~~6. When an eligible individual is placed on the waiting list for the HCBS-CIH waiver, the case manager shall provide a written notice of the action in accordance with section 8.057 et seq.~~

~~7. As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for the HCBS-CIH waiver in the order of the individual's placement on the waiting list~~

~~8. When an opening for the HCBS-CIH waiver becomes available the Department will provide written notice to the Case Management Agency.~~

~~9. Within ten business days of notification from the Department that an opening for the HCBS-CIH waiver is available the Case Management Agency shall:~~

~~a. Reassess the individual for level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.~~

~~b. Update the existing level of care assessment in the official MemberClient record if less than six months has elapsed since the date of the previous assessment.~~

~~c. Reassess for eligibility criteria as set forth at 8.517.5.~~

~~d. Notify the Department of the individual's eligibility status.~~

~~8.517.7 START DATE FOR SERVICES~~

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~~8.517.7.A. The start date of eligibility for Home and Community-Based Services for Complementary and Integrative Health (HCBS-CIH)waiver services shall not precede the date that all of the requirements at Section 8.517.5, have been met. The first date for which HCBS-CIH waiver services may be reimbursed shall be the later of the following:~~

~~1. The date at which financial eligibility is effective.~~

~~2. The date at which the level of care and targeting criteria are certified.~~

~~3. The date at which the individual agrees to accept services and signs all necessary intake and service planning forms.~~

~~4. The date of discharge from the hospital or nursing facility.~~

~~8.517.8 CASE MANAGEMENT FUNCTIONS~~

~~8.517.8.A. The requirements at Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH)waiver.~~

~~8.517.9 PRIOR AUTHORIZATION OF SERVICES~~

~~8.517.9.A. All Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services must be prior authorized by the Department or its agent.~~

~~8.517.9.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.~~

~~8.517.9.C. Claims for services are not reimbursable if:~~

~~1. Services are not consistent with the Member~~Client's documented medical condition and functional capacity;

~~2. Services are not medically necessary or are not reasonable in amount, scope, frequency, and duration;~~

~~3. Services are duplicative of other services included in the Member~~Client's Support Plan;

~~4. The Member~~Client is receiving funds to purchase services; or

~~5. Services total more than 24 hours per day of care.~~

~~8.517.9.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.~~

~~8.517.9.E. Payment for HCBS-CIH waiver services is also conditional upon:~~

~~a. The Member~~Client's eligibility for HCBS-CIH waiver services;

~~b. The provider's certification status; and~~

~~c. The submission of claims in accordance with proper billing procedures.~~

~~8.517.9.F. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulation and necessary to meet the Member~~Client's needs.

~~8.517.9.G. Services requested on the PAR shall be supported by information on the Long-term Care Support Plan and written documentation from the income maintenance technician of the Member~~Client's current monthly income.

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~~8.517.9.H. The PAR start date shall not precede the start date of HCBS-CIH eligibility in accordance with Section 8.517.7.~~

~~8.517.9.I. The PAR end date shall not exceed the end date of the HCBS-CIH eligibility certification period.~~

~~8.517.10 PROVIDER AGENCIES~~

~~8.517.10.A. HCBS-SCI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.~~

~~8.517.11 COMPLEMENTARY AND INTEGRATIVE HEALTH SERVICES~~

~~Complementary and Integrative Health Services are limited to Acupuncture, Chiropractic Care, and Massage Therapy as defined at Section 8.517.2.~~

~~8.517.11.A. Inclusions~~

~~1. Acupuncture used for the treatment of conditions or symptoms related to the MemberClient's qualifying condition and inability to independently ambulate.~~

~~2. Chiropractic Care used for the treatment of conditions or symptoms related to the MemberClient's qualifying condition and inability to independently ambulate.~~

~~3. Massage Therapy used for the treatment of conditions or symptoms related to the MemberClient's qualifying condition and inability to independently ambulate.~~

~~8.517.11.B. Exclusions / Limitations~~

~~1. Complementary and Integrative Health Services shall be provided only for the treatment of conditions or symptoms related to the MemberClient's qualifying condition and inability to independently ambulate.~~

~~2. Complementary and Integrative Health Services shall be limited to the MemberClient's assessed need for services as determined by the Complementary and Integrative Health Provider and documented in the Complementary and Integrative Health Care Plan.~~

~~3. Complementary and Integrative Health Services shall be provided in an approved outpatient setting in accordance with 8.517.11.C.2 or in the MemberClient's residence.~~

~~4. Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.C.~~

~~5. MemberClients receiving Complementary and Integrative Health Services shall participate in an independent evaluation to determine the effectiveness of the services.~~

~~6. The Complementary and Integrative Health Services benefit is limited as follows:~~

~~a. A MemberClient may receive each of the three individual Complementary and Integrative Health Services on a single date of service.~~

~~b. A MemberClient shall not receive more than four (4) units of each individual Complementary and Integrative Health Service on a single date of service.~~

~~c. A MemberClient shall not receive more than 204 units of a single Complementary and Integrative Health service during a 365-day certification period.~~

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~~d. A MemberClient shall not receive more than 408 combined units of all Complementary and Integrative Health Services during a 365-day certification period.~~

~~8.517.11.C. Certification Standards~~

~~1. Organization and Staffing~~

~~a. Complementary and Integrative Health Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.~~

~~b. Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (C.R.S § 12-200-101 et seq) and have at least (1) year experience practicing Acupuncture at a rate of 520 hours per year; OR (1) year of experience working with individuals with paralysis or other long term physical disabilities.~~

~~c. Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (C.R.S. § 12-215-101 et seq) and have at least (1) year experience practicing Chiropractic at a rate of 520 hours per year; OR (1) year of experience working with individuals with paralysis or other long term physical disabilities.~~

~~d. Massage Therapists shall be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (C.R.S. § 12-235-101, et seq) and have at least (1) year experience practicing Massage Therapy at a rate of 520 hours per year; OR (1) year of experience working with individuals with paralysis or other long term physical disabilities.~~

~~2. Environmental Standards for Complementary and Integrative Health Services provided in an outpatient setting.~~

~~a. Complementary and Integrative Health Providers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. They shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.~~

~~b. Policies shall be developed and procedures implemented for the effective control of insects, rodents, and other pests.~~

~~c. All wastes shall be disposed in compliance with local, state and federal laws.~~

~~d. A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.~~

~~e. Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.~~

~~f. Outpatient settings shall be constructed and maintained to ensure access and safety.~~

~~g. Outpatient settings shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.~~

~~3. Failure to comply with the requirements of this rule may result in the revocation of the Complementary and Integrative Health Provider certification.~~

~~8.517.11.D COMPLEMENTARY AND INTEGRATIVE HEALTH CARE PLAN~~

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1. Complementary and Integrative Health Providers shall:

a. Guide the development of the Complementary and Integrative Health Care Plan in coordination with the memberclient and/or memberclient's representative.

b. Recommend the appropriate modality, amount, scope, and duration of the Complementary and Integrative Health Service(s) within the established limits as listed at 8.517.11.B.

c. Recommend only services that are necessary and appropriate and will be rendered by the recommending Complementary and Integrative Health Provider.

d. Maintain memberclient records as established at Section 8.487.16. MemberClient records shall be made available to the Department or designated entity upon request and demonstrate the completion of Complementary and Integrative Health Providers requirements above.

2. The Complementary and Integrative Health Provider shall reassess the Complementary and Integrative Health Care Plan annually or more frequently as necessary. The reassessment shall include a visit with the memberclient.

3. The Complementary and Integrative Health Care Plan shall be developed using Department prescribed form(s) or template(s).

4. The Complementary and Integrative Health Care Plan shall include the amount, scope, and duration of recommended Complementary and Integrative Health Services (CIHS).

5. Recommendations for CIHS on the Complementary and Integrative Health Care Plan will guide case managers in completing the Prior Authorization Request (PAR).

6. CIHS will be added to the PAR only if recommended in the Complementary and Integrative Health Care Plan and agreed to by the memberclient.

8.600 Services for Individuals with Intellectual and Developmental Disabilities

8.600.1 Authority

A. These rules are promulgated under the authorities established in Section 25.5-10, C.R.S.

B. These rules and the program guidelines, standards and policies of the Colorado Department of Health Care Policy and Financing, These rules and the program guidelines, standards and policies of the Colorado Department of Health Care Policy and Financing, shall apply to all community centered boards and, service agencies and regional centers receiving funds administered by the Colorado Department of Health Care Policy and Financing.

8.600.2 Scope and Purpose

These rules govern services and supports for individuals with developmental disabilities authorized and funded in whole or in part through the Colorado Department of Health Care Policy and Financing. These services and supports include the following, as provided by the Colorado

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~~Revised Statutes and through annual appropriation authorizations by the Colorado General Assembly:~~

~~A. Services and supports provided to residents of a State operated facility or program or purchased by the Department.~~

~~B. The purchase of services and supports through Community Centered Boards, case management agencies, and service agencies.~~

~~C. Other services and supports specifically authorized by the Colorado General Assembly.~~

~~D. Services and supports funded through the Home and Community-Based Services waivers under Sections 1915(c), 1902(a)(10), and 1902(a)(1) of the Social Security Act and under Section 25.5-4-401, et seq., C.R.S.~~

~~8.600.3 Consequences for Non-Compliance~~

~~A. Pursuant to Title 25.5, Article 10, C.R.S., upon a determination by the Executive Director or designee that services and supports have not been provided in accordance with the program or financial administration standards contained in these rules, the Executive Director or designee may reduce, suspend, or withhold payment to a community centered board, service agency under contract with a community centered board, or service agency from which the Department purchases services or supports directly.~~

~~B. Prior to initiating action to reduce, suspend, or withhold payment to a community centered board or service agency for failure to comply with rules and regulations of the Department, the Executive Director or designee shall specify the reasons therefor in writing and shall specify the actions necessary to achieve compliance.~~

~~C. The Executive Director or designee may revoke the designation of a community centered board upon a finding that the community centered board is in violation of provisions of Section 25.5-10, C.R.S., other state or federal laws, or these rules.~~

~~8.600.4 Definitions~~

~~As used in these rules, unless the context requires otherwise:~~

~~"Abuse" is as defined at Sections 16-22-102 (9), 19-1-103, 25.5-10-202 (1) (a)-(c), and 26.3.1-101 C.R.S..~~

~~"Algorithm" means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Member~~Clients into one of six support levels in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.~~

~~"Assistive Technology Devices" means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.~~

~~"Assistive Technology Services" includes, but is not limited to, the evaluation of a person's need for assistive technology; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and, training the individual, or if appropriate a family member, to use the devices effectively.~~

~~"Authorized Representative" means an individual designated by a Member~~Client or by the parent or guardian of the Member~~Client, if appropriate, to assist the Member~~Client in acquiring or utilizing services and supports, this does not include the duties associated with an

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~~Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined in 8.510.1.~~

~~"Authorized Services" means those services and supports authorized pursuant to Section 25.5-10-206, C.R.S., which the Department shall provide directly or purchase subject to available appropriations for persons who have been determined to be eligible for such services and supports and as specified in the eligible person's individualized plan.~~

~~"Caretaker" is as defined at Section 25.5-10-202(1.6)(a)-(c), C.R.S.~~

~~"Caretaker Neglect" is as defined at Section 25.5-10-202(1.8)(a)-(c), C.R.S.~~

~~"Case Management Agency" (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.~~

~~"Challenging Behavior" means behavior that puts the person at risk of exclusion from typical community settings, community services and supports, or presents a risk to the health and safety of the person or others or a significant risk to property.~~

~~"Member~~Client" means an individual who has met Long-Term Services and Supports (LTSS) eligibility requirements and has been offered and agreed to receive Home and Community Based Services (HCBS) in the Children's Extensive Supports (HCBS-CES) waiver, the HCBS waiver for Children's Habilitation Residential Program (CHRP), the HCBS waiver for Persons with Developmental Disabilities (HCBS-DD), Family Support Services Program (FSSP),or the Supported Living Services (HCBS-SLS) waiver.

~~"Community Centered Board" means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.~~

~~"Comprehensive Review of the Person's Life Situation" means a thorough review of all aspects of the person's current life situation by the program approved service agency in conjunction with other members of the interdisciplinary team.~~

~~"Comprehensive Services" means habilitation services and supports that provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services include residential habilitation services and supports, day habilitation services and supports and transportation.~~

~~"Consent" means an informed assent, which is expressed in writing and is freely given. Consent shall always be preceded by the following:~~

~~A. A fair explanation of the procedures to be followed, including an identification of those which are experimental;~~

~~B. A description of the attendant discomforts and risks;~~

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~~C. A description of the benefits to be expected;~~

~~D. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;~~

~~E. An offer to answer any inquiries regarding the procedure;~~

~~F. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,~~

~~G. A statement that withholding or withdrawal of consent shall not prejudice future provision of appropriate services and supports to individuals.~~

~~"Developmental Delay" means that a child meets one or more of the following:~~

~~A. A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more of the following:~~

~~1. Chromosomal conditions associated with delays in development,~~

~~2. Congenital syndromes and conditions associated with delays in development,~~

~~3. Sensory impairments associated with delays in development,~~

~~4. Metabolic disorders associated with delays in development,~~

~~5. Prenatal and perinatal infections and significant medical problems associated with delays in development,~~

~~6. Low birth weight infants weighing less than 1200 grams, or~~

~~7. Postnatal acquired problems resulting in delays in development.~~

~~B. A child less than five (5) years of age who is significantly delayed in development in one or more of the following areas:~~

~~1. Communication,~~

~~2. Adaptive behavior,~~

~~3. Social-emotional,~~

~~4. Motor,~~

~~5. Sensory, or~~

~~6. Cognition.~~

~~C. A child less than three (3) years of age who lives with one or both parents who have a developmental disability.~~

~~"Critical Incident" means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to: Injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death~~

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~~"Developmental Disabilities Professional" means a person who has at least a Bachelor's Degree and a minimum of two (2) years' experience in the field of developmental disabilities or a person with at least five (5) years of experience in the field of developmental disabilities with competency in the following areas:~~

~~A. Understanding of civil, legal and human rights;~~

~~B. Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies;~~

~~C. Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.~~

~~"Developmental Disability" means a disability that:~~

~~A. Is manifested before the person reaches twenty-two (22) years of age;~~

~~B. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria below at C, 1 and/or C, 2; and,~~

~~C. Is attributable to an intellectual and developmental disability or related conditions which include Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found 42 U.S.C. § 15002, et seq., shall not apply.~~

~~1. "Impairment of general intellectual functioning" means that the person has been determined to have a full scale intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15).~~

~~a. A secondary score comparable to the General Abilities Index for a Wechsler Intelligence Scale that is two or more standard deviations below the mean may be used only if a full scale score cannot be appropriately derived.~~

~~b. Score shall be determined using a norm-referenced, standardized test of general intellectual functioning comparable to a comprehensively administered Wechsler Intelligence Scale or Stanford-Binet Intelligence Scales, as revised or current to the date of administration. The test shall be administered by a licensed psychologist or a school psychologist.~~

~~c. When determining the intellectual quotient equivalent score, a maximum confidence level of ninety percent (90%) shall be applied to the full scale score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the Applicant being determined to have a developmental disability.~~

~~2. "Adaptive behavior similar to that of a person with intellectual disability " means that the person has an overall adaptive behavior composite or equivalent score that is two or more standard deviations below the mean.~~

~~a. Measurements shall be determined using a norm-referenced, standardized assessment of adaptive behaviors that is appropriate to the person's living environment and comparable to a comprehensively administered Vineland Scale of Adaptive Behavior, as revised or current to the date of administration. The assessment shall be administered and determined by a professional qualified to administer the assessment used.~~

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~~b. When determining the overall adaptive behavior score, a maximum confidence level of ninety percent (90%) shall be applied to the overall adaptive behavior score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the Applicant being determined to have a developmental disability.~~

~~D. A person shall not be determined to have a developmental disability if it can be demonstrated such conditions are attributable to only a physical or sensory impairment or a mental illness.~~

~~"Emergency", as used in Section 8.608.3 regarding restraint, means a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm.~~

~~"Emergency Control Procedure" means an unanticipated use of a restrictive procedure or restraint in order to keep the person receiving services and others safe.~~

~~"Executive Director" means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.~~

~~"Exploitation" is as defined in Section 25.5-10-202(15.5)(a)-(d) and 26-3.1-101 C.R.S.~~

~~"Extreme Safety Risk to Self" means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a MemberClient's support level. This factor shall be identified when a MemberClient:~~

~~A. Displays self-destructiveness related to self-injury, suicide attempts or other similar behaviors that seriously threaten the MemberClient's safety; and,~~

~~B. Has a rights suspension in accordance with Section 8.604.3 or has a court order that imposes line of sight supervision unless the MemberClient is in a controlled environment that limits the ability of the MemberClient to harm himself or herself.~~

~~"Family", as used in rules pertaining to support services and the Family Support Services Program means a group of interdependent persons residing in the same household that consists of a family member with a developmental disability or a child under the age of five (5) years with a developmental delay, and one or more of the following:~~

~~A. A mother, father, brother(s), sister(s) or any combination; or,~~

~~B. Extended blood relatives such as grandparent(s), aunt(s) or uncle(s); or,~~

~~C. An adoptive parent(s); or,~~

~~D. One or more persons to whom legal custody of a person with a developmental disability has been given by a court; or,~~

~~E. A spouse and/or his/her children.~~

~~"Family Support Council" means the local group of persons within the Community Centered Board's designated service area who have the responsibility for providing guidance and direction to the Community Centered Board for the implementation of the Family Support Services Program.~~

~~"Family Support Plan (FSP)" means a plan which is written for the delivery of family support services as specified in Section 8.613.~~

~~"Functional Analysis" means a comprehensive analysis of the medical, social, environmental, and personal factors that may influence current behavior. This analysis shall also investigate the person's ability to communicate, analyze whether the current behavior is a means to~~

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~~communicate, and identify historical factors which may contribute to the understanding of the current behavior.~~

~~"Guardian" means a person who has qualified as a guardian of a minor or incapacitated person by testamentary or count appointment but excludes a Guardian Ad Litem.~~

~~"Harmful Act" is as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.~~

~~"Home and Community-Based Services Waivers (HCBS)" means HCBS waiver programs, including the Home and Community Based Waiver for the Developmentally Disabled (HCBS-DD), Supported Living Services (SLS) and Children's Extensive Support (CES). "Host Home Provider" is an individual(s)who provides residential supports in his/her home to persons receiving comprehensive services who are not family members as defined in Section 25.5-10-202(16), C.R.S. A host home provider is not a developmental disabilities service agency pursuant to Section 8.602 of these rules.~~

~~"Human Rights Committee" means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and reviewing investigations of allegations of mistreatment of persons with intellectual and developmental disabilities who are receiving services or supports.~~

~~"Individual Service and Support Plan (ISSP)" means a plan of intervention or instruction which directly addresses the needs identified in the person's Individualized Plan and which provides specific direction and methodology to employees and contractors providing direct service to a person.~~

~~"Interdisciplinary Team (IDT)" means a group of people convened by a Community Centered Board which shall include the person receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by such person's needs and preferences, who are assembled in a cooperative manner to develop or review the individualized plan.~~

~~"Mechanical Restraint" means the use of devices intended to restrict the movement or normal functioning of a portion of an individual's body. Mechanical restraint does not include the use of protective devices used for the purpose of providing physical support or prevention of accidental injury.~~

~~"Minimum Effective Dose" means the smallest medication dosage necessary to produce the intended effect.~~

~~"Mistreated" or "Mistreatment" is as defined at Sections 25.5-10-202(29.5)(a)-(d) and 26-3.1-101 C.R.S.:~~

~~"Notice" means written notification hand delivered to or sent by first class mail that contains at least all of the following:~~

~~A. The proposed action;~~

~~B. The reason or reasons for that action;~~

~~C. The effective date of that action;~~

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~~D. The specific law, regulation, or policy supporting the action;~~

~~E. The responsible agency with whom a protest of the action may be filed including the name and address of the director.~~

~~F. The dispute resolution procedure, including deadlines, in conformity with Section 8.605 and procedures on accessing agency records:~~

~~1. For disputes involving individuals as defined in Section 8.605.2, information on availability of advocacy assistance, including referral to publicly funded legal services, corporation, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under 42 U.S.C. 15001, the Developmental Disabilities Assistance and Bill of Rights Act; and,~~

~~2. For disputes involving individuals as defined in Section 8.605.2 an explanation of how the agency will provide services to a currently enrolled person during the dispute resolution period, including a statement that services will not be terminated during the appeal. Such explanation will include a description of services currently received.~~

~~"Parent" means the biological or adoptive parent.~~

~~"Person-Centered Support Plan" means as defined in Section 8.390.1 DEFINITIONS.~~

~~"Physical Restraint" means the use of manual methods to restrict the movement or normal functioning of a portion of an individual's body through direct physical contact by others except for the purpose of providing assistance/prompts. Assistance/prompts is the use of manual methods to guide or assist with the initiation or completion of and/or support the voluntary movement or functioning of an individual's body through the use of physical contact by others except for the purpose of providing physical restraint.~~

~~"PRN" (Pro Re Nata) means giving drugs on an "as needed" basis through a standing prescription or standing order.~~

~~"Program Approved Service Agency" means a developmental disabilities service agency or typical community service agency as defined in Section 8.602, which has received program approval by the Department pursuant to Section 8.603 of these rules.~~

~~"Program Services" means an organized program of therapeutic, habilitative, specialized support or remedial services provided on a scheduled basis to individuals with developmental disabilities.~~

~~"Prospective New Service Agency" means an individual or any publicly or privately operated program, organization or business that has completed and submitted an application with a Community Centered Board for selection and approval as a service agency to provide comprehensive services.~~

~~"Public Safety Risk-Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Member~~Client's support level. This factor shall be identified when a ~~Member~~Client ~~has:~~

~~A. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,~~

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B. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the MemberClient is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

"Public Safety Risk-Not Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a MemberClient's support level. This factor shall be identified when a MemberClient has:

A. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,

B. A rights suspension in accordance with Section 8.604.3or through parole or probation, or a court order that imposes line of sight supervision unless the MemberClient is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

"Rate" means the amount of money, determined by a standardized rate setting methodology, reimbursed for each unit of a defined waiver service provided to a MemberClient by a qualified provider.

"Referral" means any notice or information (written, verbal, or otherwise) presented to a Community Centered Board which indicates that a person may be appropriate for services or supports provided through the developmental disabilities system and for which the Community Centered Board determines that some type of follow-up activity for eligibility is warranted.

"Request for Provider (RFP)" means a formal process for case managers to notify Program Approved Provider Agencies when a MemberClient is seeking authorized services including, but not limited to, a non-identifying description of the memberclient's support and supervision needs.

"Regional Center" means a facility or program operated directly by the Department of Human Services, which provides services and supports to persons with developmental disabilities.

"Respondent" means a person participating in the SIS assessment who has known the MemberClient for at least three months and has knowledge of the MemberClient's skills and abilities. The respondent must have recently observed the MemberClient directly in one or more places such as home, work, or in the community.

"Restrictive Procedure" means any of the following when the intent or plan is to bring an individual's behavior into compliance:

A. Limitations of an individual's movement or activity against his or her wishes; or,

B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences.

"Request for Developmental Disability Determination" means written formal documentation, either handwritten or a signed standardized form, which is submitted to a Community Centered Board requesting that a determination of developmental disability be completed.

"Safety Control Procedure" means a restrictive procedure or restraint that is used to control a previously exhibited behavior which is anticipated to occur again and for which the planned method of intervention is developed in order to keep the person and others safe.

"Screening for Early Intervention Services" means a preliminary review of how a child is developing and learning in comparison to other similarly situated children. "Seclusion" means the placement of a MemberClient alone in a closed room for the purpose of punishment. Seclusion for any purpose is prohibited.

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~~"Service Agency" means an individual or any publicly or privately operated program, organization or business providing services or supports for persons with developmental disabilities.~~

~~"SIS Interviewer" means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department approved trainer using the Department approved curriculum. SIS Interviewers must maintain a standard for conducting SIS assessments as measured through periodic interviewer reliability reviews.~~

~~"Statewide Database" means the state web-based system that contains consumer-related demographic and program data.~~

~~"Support Coordinating Agency" means a Community Centered Board which has been designated as the agency responsible for the coordination of support services (supported living services for adults and the children's extensive support program) within its service area.~~

~~"Supports Intensity Scale" (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Member~~Client ~~well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.~~

~~"Support Level" means a numeric value determined using an algorithm that places Member~~Clients ~~into groups with other Member~~Clients ~~who have similar overall support needs.~~

~~"Undue Influence" means use of influence to take advantage of a person with an intellectual or developmental disability's vulnerable state of mind, neediness, pain, or emotional distress.~~

~~"Waiver Services" means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid State Plan services.~~

~~8.600.5 OTHER PROVISIONS~~

~~A. All regional centers, community centered boards, and program approved service agencies shall maintain copies of statutes and rules and regulations relevant to the provision of authorized services, and shall ensure that appropriate employees and contractors have access to such copies and are oriented to the content of the statutes and rules.~~

~~B. All regional centers, community centered boards, and program approved service agencies shall have written policies and procedures concerning the exercise and protection of individual rights pursuant to Title 25.5, Article 10, C.R.S.~~

~~C. All regional centers, community centered boards, and program approved service agencies shall have written procedures for the protest of agency decisions or actions of the agency's employees or contractors by the person receiving services or parent of a minor or guardian of such person, or authorized representative if within the scope of his/her duties, which procedures shall meet requirements of Section 8.605 of these rules. Interpretation in native languages other than English and through such modes of communication as may be necessary shall be made available upon request.~~

~~D. Community centered boards shall serve as the single point of entry into authorized services funded by the State of Colorado, Department of Health Care Policy and Financing, both in community settings and regional centers.~~

~~E. Persons with developmental disabilities will be considered for referral, enrollment or discharge from authorized services, funded in whole or in part by the State of Colorado, without discrimination on the basis of race, religious or political affiliation, gender, national origin, age or disability.~~

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~~F. All regional centers, community centered boards, and service agencies shall provide information and reports as required by the Department including, but not limited to, data necessary for the Department's data system, COPAR, billing records, and legislative reports~~

~~G. A waiver of the specific requirements of these rules and regulations may be granted for a specifically stated duration by the Department in accordance with this section:~~

~~1. A waiver of these rules and regulations may be granted only upon a finding that the waiver would not adversely affect the health, safety, welfare or rights and privileges of persons with developmental disabilities and upon further finding that a valid programmatic reason exists or a demonstrated financial hardship on the community centered board or service agency seeking the waiver such that the provision of necessary services and supports to persons served would be endangered.~~

~~2. The Department shall not waive any requirement of these rules and regulations that would in any way jeopardize the receipt of federal financial participation or other funding necessary for the provision of services and supports to persons with developmental disabilities, nor shall the Department approve waivers of rules and regulations that would in any way materially affect the rights and privileges of individuals with developmental disabilities as provided by the Colorado Revised Statutes and other applicable state and federal laws and regulations.~~

~~3. No waiver granted by the Department shall in any way constitute a waiver of the obligations of the community centered board or service agency under rules and regulations of other departments and agencies of the State of Colorado or the federal government.~~

~~4. The community centered board or, service agency or regional center seeking a waiver of any of the rules and regulations contained herein bears the burden of proof in demonstrating that the waiver sought is in conformity with these provisions.~~

~~H. The community centered board and, service agency, and regional center shall allow access by authorized personnel of the Department, or designee, for the purpose of reviewing services and supports which are funded by the Department and shall cooperate with the Department in the evaluation of such services and supports.~~

~~8.600.7 INCORPORATION BY REFERENCE~~

~~Any material that has been incorporated by reference in these rules does not include any later amendments or editions to the incorporated material after the referenced date provided. Pursuant to section 24-4-103(12.5), C.R.S., the Department maintains copies of the incorporated material in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.~~

~~8.601 ADMINISTRATIVE SERVICES~~

~~8.601.1 COMMUNITY CENTERED BOARDS (CCB)~~

~~A. Annually, any private corporation, for profit or not for profit, seeking designation as a Community Centered Board shall submit an application for designation to the Department.~~

~~1. Applications shall be submitted in a form and manner specified by the Department which shall be made available to applicants upon request.~~

~~2. The Department shall notify all applicants by first class mail of its determination of designation or non-designation by May 15 of each year.~~

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~~3. The designation shall cover a twelve (12) month period beginning July 1 and ending June 30.~~

~~4. Designation of a Community Centered Board shall be based on the following factors:~~

~~a. Utilization of existing service agencies, social networks or natural sources of support in the designated service area. This shall be determined and based on an actual count of service agencies within a designated service area and a description of utilization of such agencies as well as a description of existing social networks and natural sources of support which were utilized.~~

~~b. Encouragement of competition among service agencies within the designated service area to provide newly identified services or supports, the variety of service agencies available to the person receiving services within the designated service area, and the demonstrated effort to purchase new or expanded services or supports from service agencies other than those affiliated with the Community Centered Board. This shall be evaluated based on the ability of the applicant to substantiate such activities.~~

~~c. Utilization of state funded services and supports administered at the local level, including, but not limited to, public education, social services, public health, and rehabilitation programs. This shall be determined based on a description of local utilization of state funded services and on a review of the previous fiscal year audit, current budget submission and the designated service area plan.~~

~~d. Quality of services and supports provided for persons with developmental disabilities. Quality shall be measured based on compliance with federal and state licensing or program approval requirements, accreditation reports, agencies' self-evaluation efforts, and Department's quality assurance monitoring activities. Other resources to evaluate quality that may be considered include: analysis of disputes and complaints, use of grievance procedures, and measures of satisfaction by persons receiving services or supports.~~

~~e. The establishment of new services and supports for the prevention of institutionalization, the support of deinstitutionalization, and a commitment to innovative, effective, and inclusive services and supports for persons with developmental disabilities. This shall be determined based on past performance, documented use of innovative and inclusive service and support approaches, effectiveness measures, and a description of the Community Centered Board's future plans.~~

~~f. The demonstrated effort of the applicant to pursue authorized services and supports for all eligible persons within the designated service area. This shall be determined based on both past performance and the applicant's written plan for addressing needed but unavailable services and supports.~~

~~g. Compliance with the transparency requirements included in Section 25.5-10-209(6)-(8), C.R.S. and these rules.~~

~~5. Any applicant that has not previously functioned as a Community Centered Board shall respond to the application process with statements of intent and plans in any area where past performance cannot be documented.~~

~~B. If the Department determines that the Community Centered Board is in substantial compliance, the Community Centered Board shall receive designation. Upon designation, a Community Centered Board shall agree by contract to meet all requirements of Section 25.5-10, C.R.S., all rules and the following requirements:~~

~~1. In order to assure public accountability, the Community Centered Board shall be under the control and direction of a board of directors or trustees, pursuant to Section 25.5-10-209(2)(a), C.R.S.~~

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2. Staff members of the Community Centered Board, employees or board members of service agencies, or contractors to the Community Centered Board or service agencies providing services to individuals through the specific Community Centered Board may not serve on the governing board.

3. Community Centered Board governing board members shall recuse themselves from proceedings which may affect their direct or indirect financial interests.

4. The Community Centered Board shall notify the Department in writing within ten (10) business days of any changes in the board of directors.

5. Each Community Centered Board shall provide to the incoming members of its board of directors training in such topics as the duties of a board member, the financial and fiduciary responsibilities assumed by board members, the intellectual and developmental disability system in the state, the overall business functions of the Community Centered Board, and any other matters that will, in the determination of the community centered board, allow the board member to better understand and fulfill his or her obligations to the board of directors and the community centered board and the role played by Community Centered Boards in the state in connection with the delivery of services for persons with intellectual and developmental disabilities.

a. The Community Centered Board shall keep documentation indicating that each board member has received training materials. This documentation and copies of all training materials shall be provided to the department upon request.

6. The board of directors of each designated Community Centered Board shall meet no less than once each quarter of the calendar year.

7. Each Community Centered Board shall provide a direct e-mail address to each member of its board of directors on the website of the community centered board. The e-mail address selected must specify the name of the individual board member and make reference to the particular community centered board for which he or she serves as a member of the board of directors.

a. An e-mail that is sent to a member of the board of directors of a community centered board shall not be filtered by an employee of the Community Centered Board. The CCB shall insure that all emails addressed to a member of the board of directors are provided to that board member.

b. In the event a board member is unable to access a computer or needs assistance with e-mail, the Community Centered Board shall provide appropriate assistance, including providing e-mails in alternative formats upon request or mailing correspondence through the U.S. postal service.

8. The board of directors or trustees shall adopt specific bylaw provisions which ensure that they are in compliance with all provisions of Section 25.5-10-209(2)(b), C.R.S., and:

a. Notices of meetings of the board of directors shall be posted in an identified public place at the Community Centered Board.

b. The Community Centered Board shall post the date, time, and location of each regularly scheduled meeting of its board of directors on the website of the Community Centered Board not less than fourteen business days prior to the date of the meeting.

c. The Community Centered Board shall post on the website of the Community Centered Board the date, time, and location of any special or emergency meeting of the board of directors not less than twenty-four hours before the meeting.

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~~d. Each Community Centered Board shall post the agenda for each meeting of its board of directors on the website of the Community Centered Board not less than seven business days prior to the date of the meeting. Agendas shall remain posted on the website for at least three months.~~

~~e. The Community Centered Board shall post on the website of the community centered board the agenda of any special or emergency meeting of the board of directors not less than twenty-four hours before the meeting. Special or emergency meeting agendas shall remain posted on the website for at least three months.~~

~~f. The board of directors of each Community Centered Board shall present the financial statements of the corporation for the approval of the board at each regularly scheduled meeting of the board of directors. The financial statements must reflect accurate and current financial information and be prepared using generally accepted accounting principles. Where exigent circumstances are present that materially affect the preparation of the financial statements on a monthly basis, such statements may be presented for the approval of the board of directors at the next regularly scheduled meeting of the board but not less than at least once each quarter of the calendar year.~~

~~g. Each Community Centered Board shall post on the website of the Community Centered Board the minutes of each meeting of its board of directors as such minutes are approved by the board of directors. Each Community Centered Board shall also post on the website of the Community Centered Board any additional documents that were distributed to the board at such meeting that were not, as of that date, already posted on the website of the Community Centered Board unless the public distribution of such documents, or any portion of such documents, is otherwise prohibited pursuant to the privacy requirements specified in the health insurance portability and accountability act or as otherwise prohibited by law. Minutes of special meetings of the board of directors must be posted after approval by the board of the same at the board's next regular meeting.~~

~~i. Meeting minutes shall remain posted on the website of the Community Centered Board for a minimum of three calendar years.~~

~~h. All meetings of a quorum of the board at which any public business is discussed or at which any formal action may be taken shall be open to the public for input. This does not apply to those matters covered in executive session pursuant to Section 25.5-10-209(2)(b)(IV), C.R.S.~~

~~i. Each meeting of the board must allow for public comment, and the agenda must reflect this requirement. Public comment must be reasonably permitted during the board meeting to accommodate community needs.~~

~~i. This section does not apply to any chance meeting or social gathering of the board at which discussion of the public business of the board is not the central purpose.~~

~~j. Any documents related to functions of the Community Centered Board to be distributed at a meeting of the board of directors that are available for public dissemination at the time the agenda is posted must also be posted on the website of the Community Centered Board at the time the agenda is posted, and written copies of such documents must be made available for public dissemination at the board meeting. Such documents shall remain posted on the website for at least three months.~~

~~k. This posting requirement does not apply to any document, or any portion of such document, the disclosure of which requires the approval of the board of directors and which approval has not been obtained as of the time the agenda is posted or any other document, or any portion of such document, containing any information that is legally prohibited from being disclosed to the public pursuant to the privacy requirements specified in the health insurance portability and accountability act, any document that has been or will be discussed by the board of directors meeting in executive session, or any other document the disclosure of which is otherwise prohibited by law.~~

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~~l. Any contract that each Community Centered Board enters into with either the Department of Health Care Policy And Financing or the Department of Human Services must be posted on the website of the Community Centered Board in a place on the website that allows access to the public in a clear, accessible, easily operated, and uncomplicated manner not later than thirty days following approval of the contract by the board of directors of the Community Centered Board.~~

~~i. All contracts shall remain posted on the website for at least three calendar years.~~

~~9. Upon designation the Community Centered Board shall within available appropriations provide or arrange for services and supports which meet all the provisions of Section 25.5-10-209(2)(c) through (h), C.R.S., and:~~

~~a. In accordance with reporting requirements of the Department's data system, maintain and update records of persons determined to be eligible for services and supports and who are receiving case management services.~~

~~b. Provide for case management services pursuant to Section 8.607 of these rules.~~

~~c. Notify the eligible person and, if appropriate, their parents or guardian regarding the availability of services and supports pursuant to requirements of Sections 8.607 and 8.605.2.~~

~~d. Establish a Human Rights Committee(s) as required in Section 8.608.5 of these rules.~~

~~e. Devise and implement a plan for monitoring the programmatic practices of the Community Centered Board and contracted service agencies, pursuant to Section 8.607.6 in these rules.~~

~~C. Each Community Centered Board shall submit annually a written long-range plan or an annual update to that plan for its designated service area pursuant to guidelines developed by the Department.~~

~~1. The long-range plan or annual updates to the plan shall be developed through collaborative community efforts, facilitated by the community centered board, and shall include an annual public forum.~~

~~At a minimum, the designated service area planning process shall include appropriate opportunities and times for participation and input for persons with developmental disabilities who are receiving or waiting for services and supports: families who are receiving or waiting for services and supports; and service agencies under contract with the Community Centered Board.~~

~~2. Copies of the written long-range plan or annual update must be available to the public during business hours at a reasonable cost not to exceed the costs allowed in Section 24-72-205, C.R.S.~~

~~D. The Department shall review each Community Centered Board to assure that it complies with the requirements set forth in these rules.~~

~~E. The Department will maintain a website allowing for community members to make anonymous complaints regarding Community Centered Board transparency.~~

~~F. Community Centered Boards found to be in violation of section 25.5-10-209, C.R.S. or these rules shall be notified by electronic mail. Community Centered Boards shall have five (5) business days from the date of the notification to remedy any violation.~~

~~G.. Community Centered Boards remaining out of compliance after five (5) business days, shall be required to develop a corrective action plan, upon written notification by the Department. The Community Centered Board shall submit to the Department the written corrective action plan within ten (10) business days of the receipt of the written request from the Department.~~

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~~Compliance with the corrective action plan shall be monitored by the Department. Failure to timely submit or make corrections specified in the corrective action plan may result in withholding of contract payments or revocation of designation.~~

~~H. The Executive Director or designee may revoke the designation of a Community Centered Board upon a finding that the Community Centered Board is in violation of Section 25.5-10-101, C.R.S., et seq., as amended, other state or federal laws, or these rules.~~

~~Revocation of the designation of the Community Centered Board shall conform to the provisions and procedures specified in Section 24-4-104, C.R.S.~~

~~I. Once a designation has been revoked, the Executive Director or designee may designate another private corporation, for profit or not-for-profit, to perform the case management services and administrative duties of the Community Centered Board pending designation of a new Community Centered Board.~~

~~J. Any party may protest the decision of the Executive Director or designee to designate a Community Centered Board pursuant to provisions of Section 24-4-104(5), C.R.S.~~

~~8.602 SERVICE AGENCIES~~

~~A. Pursuant to section 25.5-10-202(34), C.R.S., a service agency may be an individual or any publicly or privately operated program, organization, or business providing services or supports for persons with developmental disabilities. Service agencies are classified into one of the following three categories:~~

~~1. Individual service agency is a person providing services under contract with a community centered board or program approved service agency.~~

~~2. A typical community service agency is a public or privately operated program, organization or business providing services predominantly for persons without developmental disabilities.~~

~~3. A developmental disabilities service agency is a publicly or privately operated program, organization or business providing services predominantly for persons with developmental disabilities. This includes community centered boards when they provide direct services.~~

~~B. All developmental disabilities service agencies and typical community service agencies providing comprehensive services must be approved by the Department pursuant to section 8.603.~~

~~8.602.1 SELECTION AND APPROVAL OF SERVICE AGENCIES BY COMMUNITY CENTERED BOARDS~~

~~A. Community centered boards shall select and approve all developmental disabilities service agencies as defined in section 8.602, and any typical community service agency as defined in section 8.602, providing comprehensive services to provide authorized services in a designated service area in accordance with these rules and regulations unless otherwise noted in section 8.603.A.~~

~~The community centered board shall select and approve a service agency based on information considered pertinent in determining if the service agency has adequate resources financially and programmatically to provide the services and supports needed. This shall include, but not be limited to:~~

~~1. The service agency's ability to provide the type of services and supports needed;~~

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2. Review of relevant policies and procedures of the service agency including a review, and, as appropriate, a site visit of agency programs;

3. Verification of applicable licenses, registrations or certifications;

4. A listing of banking and other fiduciary relationships of the prospective service agency;

5. A copy of the most recent fiscal audit of the agency or, if an audit has not been conducted, other financial information determined to satisfy the requirement;

6. Proof of insurance coverages;

7. A listing of the membership of the board of directors or trustees of the agency along with their affiliations, as applicable;

8. A copy of the by-laws of the agency and articles of incorporation;

9. A description of the organizational structure of the agency; and,

10. A statement of assurances from the service agency to comply with statutory and regulatory requirements and to cooperate with quality assurance surveys or reviews and related activities.

B. Any out-of-state corporation approved to provide services or supports in a designated service area shall organize a local advisory board consisting of individuals who reside within the designated service area. Such advisory board shall be representative of the community at large and include persons receiving services and their families.

C. The approval of a service agency by the community centered board carries no assurance that the service agency will receive state or federal funding from the Colorado Department of Health Care Policy and Financing or through subcontracts with community centered boards.

D. Service agencies shall allow access by authorized personnel of the Department, or designee, for the purpose of reviewing services and supports provided by the service agencies and shall cooperate with the Department in the evaluation of services and supports provided.

8.602.2 PURCHASE OF AUTHORIZED SERVICES

Subject to available appropriations, the Department shall purchase authorized services and supports through community centered boards or provide services and supports through regional centers, except that services and supports may be purchased directly from service agencies under the conditions outlined in section 25.5-10-206(4), C.R.S.

8.602.3 DEPARTMENT ALLOCATION OF RESOURCES

The Department shall determine the resources to be allocated to each designated service area based upon available resources, designated service area data, and the overall State plan. The Department will inform each community centered board of the amount of base and new resources being allocated each year. New resources are to be used in a manner that considers individuals' preferences and affords service agencies a fair and equal opportunity to provide services and supports. The process for choosing service agencies to provide services for an individual shall be in accordance with sections 8.602.4 and 8.602.5.

8.602.4 CHOICE OF SERVICE AGENCIES FOR SUPPORT SERVICES FOR AN INDIVIDUAL

A. Persons and/or their guardian, as appropriate, and families who will be receiving support services shall have the freedom to choose providers from service agencies which have been selected or selected and approved in accordance with Sections 8.602.1 and 8.603, as

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~~applicable, and section 8.609.1 and with concurrence of the support coordinating agency as defined in section 8.600.4.~~

~~B. Persons, their guardians, and authorized representative, as appropriate, shall be provided information on all providers selected and approved for support services within the service area.~~

~~8.603 PROGRAM APPROVAL BY THE DEPARTMENT~~

~~A. All service agencies approved by a community centered board to provide comprehensive services shall also be approved by the Department to provide the authorized service(s) for which they have been selected prior to delivery of such services.~~

~~The program approved service agency maintains overall responsibility for services provided to a person receiving services. A service agency may, however, arrange with an individual or typical community service agency to provide a portion of the authorized services without the individual or the typical community service agency being approved by the Department when:~~

~~1. The program approved service agency is directly involved in the provision of services and supports required by the person due to his/her developmental disabilities; or,~~

~~2. The program approved service agency directly provides the majority of services and supports to persons receiving residential, or adult habilitation day services or supports under the HCB-DD Medicaid waiver; or,~~

~~3. The services are provided by a host home provider; or,~~

~~4. Services are provided by a qualified professional in his/her professional discipline; for example, physical therapy and nursing.~~

~~B. A developmental disabilities service agency selected and approved by a community centered board to provide support services shall be approved by the Department prior to the delivery of such services when it is not otherwise approved by the Department within the service area.~~

~~C. Each community centered board shall be approved by the Department to provide support services.~~

~~D. The community centered board shall recommend to the Department a service agency for program approval and Medicaid certification only if it meets requirements set forth in section 25.5-10, C.R.S., and rules of the Department.~~

~~1. Recommendations for Department program approval shall be made in a manner prescribed by the Department.~~

~~2. The Department shall review the application for program approval for completeness and accuracy and act upon the recommendation of the community centered board.~~

~~E. Community centered boards and service agencies approved by the Department shall be regularly evaluated by the Department. Evaluations shall be conducted by the Department or, with Department concurrence, the following may be substituted:~~

~~1. Accreditation of program approved service agencies providing adult day habilitation services and supports by a national accreditation body acceptable to the Department; or,~~

~~2. Licensure, certification or approval acceptable to the Department from another state regulatory body; or,~~

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~~3. Some combination of the above approaches which provides oversight of both programmatic and safety areas.~~

~~F. Program approval shall be renewed when, based on the results of the evaluation, the community centered board or service agency is found to be in substantial compliance with requirements pertaining to the program evaluated.~~

~~G. Program approval shall lapse for a service agency not under contract with a community centered board or the Department unless otherwise continued by the Department; and,~~

~~H. The Department may revoke program approval upon a finding that the service agency is in violation of section 25.5-10, C.R.S., other state or federal laws, or these rules.~~

~~Revocation shall conform to the provisions and procedures specified in section 24-4-104, C.R.S.~~

~~8.603.1 CONTRACTUAL ISSUES BETWEEN COMMUNITY CENTERED BOARD AND PROGRAM APPROVED SERVICE AGENCY REGARDING PERFORMANCE~~

~~A. All service agencies are responsible for the services they provide directly. In addition, program approved service agencies are responsible for any services provided through contract.~~

~~B. If purchased services and supports fall below the acceptable level of service provision, which shall be determined through on-site review of programs and other monitoring against rules and regulations of the Department, the community centered board shall notify the program approved service agency of its findings and shall provide the agency reasonable opportunity to comply with requirements. The community centered board shall also notify the Department of its findings.~~

~~Nothing in this procedure shall prohibit the community centered board from taking appropriate action when necessary to preserve the health, safety or welfare of persons receiving services or the public.~~

~~C. Prior to terminating a contract with a program approved service agency, the community centered board must provide the service agency with notice of such action, including documentation of the reasons for such action.~~

~~D. Prior to terminating a contract with a program approved service agency the community centered board shall notify the Department of the grounds for termination, including specific instances of failure of the program approved service agency in question to comply with requirements of section 25.5-10-101, C.R.S., et seq., and these rules.~~

~~8.603.2 DISPUTE RESOLUTION PROCESS BETWEEN COMMUNITY CENTERED BOARD AND PROGRAM APPROVED SERVICE AGENCY FOR THE NON-RENEWAL OF AN EXISTING CONTRACT~~

~~A. The community centered board shall establish procedures and timeframes which provide reasonable notice, at a minimum thirty (30) days, to a service agency in the event it decided not to renew a contract with the program approved service agency.~~

~~B. The program approved service agency whose contract the community centered board has decided not to renew shall be provided an opportunity to present its concerns by first protesting the non-renewal to the community centered board.~~

~~1. The community centered board shall provide a written response to the program approved service agency within fifteen (15) days of the service agency protesting the non-renewal of a contract.~~

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~~2. As soon as possible after reaching the decision not to renew, the community centered board shall send notice as defined in section 8.600.4 to all affected individuals.~~

~~3. The community centered board shall inform the Department of any decision to not renew a contract with a program approved service agency. Within seven (7) days the Department may:~~

~~a. Require a transition plan for providing services to the affected individuals;~~

~~b. Require that any additional information, as defined by the Department, be sent to all affected individuals; and,~~

~~c. Require that the community centered board and program approved service agency mediate the dispute.~~

~~8.603.3 FISCAL AND PERSONNEL ADMINISTRATION~~

~~Medicaid-funded services for persons with developmental disabilities are administered by the Colorado Department of Health Care Policy and Financing.~~

~~8.603.4 CONTRACTS/WRITTEN AGREEMENTS~~

~~A. Contracts between the Department and community centered boards or service agencies for services for persons with developmental disabilities shall comply with the contractual requirements of Chapter 3 of the State Fiscal Rules promulgated pursuant to section 24-30-202, C.R.S.~~

~~B. Contracts between the community centered board and program approved service agencies, as identified in section 8.603 of these rules, must be current and signed prior to the delivery of services. Contracts must contain any state prescribed provisions and, at a minimum, address the following:~~

~~1. The amount, duration, and scope of services to be provided.~~

~~2. The rate at which the listed services are to be reimbursed.~~

~~3. A clause stipulating the listed services are not assignable.~~

~~4. The requirements regarding submission of service provision and billing information.~~

~~5. A clause stipulating the requirement for comprehensive general liability insurance to be in effect at all times.~~

~~6. A clause specifying the requirements for cancellation of the contract by either party.~~

~~7. Actions that may be taken in situations involving suspected or alleged mistreatment, abuse, neglect or exploitation to protect the safety of the person receiving services pursuant to section 8.608.8.~~

~~C. Agreements between the community centered board or a program approved service agency and other service agencies must be in writing and signed prior to the delivery of services. Written agreements must contain any state prescribed provisions and specific language that at a minimum addresses section 8.603.4.B.1 through 7.~~

~~1. All contracts pursuant to 25.5-10-206, C.R.S., must contain the contract provisions specified by the Department. Contracts and written agreements entered into between community centered boards and service agencies may contain contract provisions in addition to those contract provisions specified by the Department. Any such additional provisions shall not contradict the Department's specified provisions nor in any way diminish or alter the provisions of these rules.~~

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2. Contracts for Medicaid-funded services shall be governed by the rules and regulations of the Colorado Department of Health Care Policy and Financing's Medical Assistance Staff Manual (10 C.C.R. 2505-10).

3. A transfer of ownership or operation of a community centered board or a program approved service agency terminates the contract and Medicaid provider certification. In order to participate in the Medicaid program, the new owner or operator of the community centered board or service agency must establish that the program meets the conditions for participation as provided in these rules and enter into a new contract and receive Medicaid provider certification. No payments to the new owner will be made by the community centered board or the State until Medicaid provider certification is granted and applicable licenses are received and a valid contract exists.

8.603.5 PAYMENT FOR SERVICES PURCHASED

A. Services purchased by community centered boards or services agencies under contract with the Department are subject to available appropriations and the amounts specified in the contract.

B. Community centered boards or service agencies under contract with the Department and service agencies under contract with the community centered board shall submit enrollment, attendance data and billing invoices in the format prescribed by the Department.

C. The development and implementation of an Individualized Plan for each eligible person, as set forth herein, is a condition of funding by the Department for services and supports. The Department shall disallow payments to community centered boards, or service agencies under direct contract with the Department, in the amount of funds provided for the eligible person for whom the Individualized Plan has not been developed and implemented for the period of time until an Individualized Plan is developed and implemented.

D. The submission of the LTC-102 form for continued stay reviews is a condition of funding by the Department for services and supports. The Department will disallow payments to the community centered board or service agency under direct contract with the Department, in the amount of funds provided for the eligible person for whom the LTC-102 form has not been submitted.

E. Program approval by the Department is a condition of Departmental funding of community centered boards and service agency programs requiring program approval as identified in section 8.603. The Department shall disallow payments to community centered boards or service agencies in the amount of funds provided for instances when program approval has not been obtained prior to delivery of program services to eligible individuals.

F. The Department shall pay to the community centered board or service agency the amount due within thirty (30) days of presentation of a billing.

G. Payment to the community centered board or service agency shall be made by using the rates established by the Department which are net of any required five percent (5%) local matching funds. Funds that require the five-percent local match will be identified in the contract for purchase of services between the Department and each service agency.

H. Local matching funds include:

1. Funds provided for general operating expenses by any political subdivision of the State;

2. Funds provided for general operating expenses through cash donations or contributions;

3. In-kind goods and services as defined by generally accepted accounting principles and Departmental policies; and,

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~~4. Donations made for a donor-restricted purpose (such as purchase of equipment or property).~~

~~I. Local matching funds may be provided by the community centered board or service agency. When either party provides the local match for the other party, the providing party must certify in writing, for audit purposes, to the other party, the following information:~~

~~1. The amount of matching funds;~~

~~2. The source of matching funds as described in section 8.603.5.G; and,~~

~~3. A statement assuring that these matching funds are not being used to meet the local matching requirement of any other state or federal program.~~

~~J. Any community centered board under contract with the Department providing services to persons with developmental disabilities which fails to meet the five percent (5%) match requirements shall document the good faith effort necessary to achieve a ratio of ninety-five percent (95%) state participation and five-percent (5%) local participation. Should the community centered board not show a good faith effort to obtain a five-percent local match, the community centered board will be subject to the administrative penalties identified in the contract with the Department.~~

~~K. Reimbursement for Residential Habilitation Services and Supports shall exclude any costs associated with room and board expenses as required by 42 C.F.R. 441.310. The maximum monthly amount charged for room and board expenses to persons receiving comprehensive services by an agency shall not exceed an amount equal to the monthly benefit for Supplemental Security Income (SSI), less an amount specified by the Department for personal needs.~~

~~L. Reimbursement for the final month of services provided (not necessarily the final month of a contract period) by a service agency shall be withheld until audits have been completed to determine that no adjustments resulting in moneys due the service agency, the State, or the persons receiving services remain unadjusted. Such reimbursement shall continue to be withheld until all questions and issues raised by the audits are resolved.~~

~~M. When providers are paid for Medicaid services based on Medicaid claims submitted by providers, these payments are made on the condition that the providers accept them as payment-in-full for the service and agree not to seek additional reimbursement for the service from the recipient or recipient's family.~~

~~Services provided in conjunction with Medicaid reimbursable services that are not themselves Medicaid reimbursable may be billed to recipients and their families.~~

~~N. Targeted case management services are only reimbursed for individuals enrolled in the HCBS-DD, Supported Living Services and Children's Extensive Support Waiver Programs. Individuals enrolled in the HCBS-DD waiver who continue to receive comprehensive habilitation services which are not billed to Medicaid because units have been exhausted continue to be eligible for targeted case management services.~~

~~O. Failure to prepare the IP and ISSP or failure to submit the IP, ULTC-100 or LTC-102 forms in accordance with Department policies and procedures shall result in the denial of reimbursement for services authorized retroactive to first date of service, and the case management agency and/or providers may not seek reimbursement for these services from the person receiving services.~~

~~1. If the community centered board makes an error in billing the Medicaid fiscal agent for services delivered by a sub-contracting service agency, and the error results in loss of Medicaid reimbursement, the community centered board shall reimburse the service agency for the amount of the loss.~~

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~~**2. If the community centered board causes an individual enrolled in Medicaid waiver services to have a break in payment authorization, the community centered board will ensure that all services continue and will be solely financially responsible for any losses incurred by other providers until payment authorization is reinstated.**~~

~~**8.603.6 ACCOUNTING SYSTEMS**~~

~~A. The community centered board or program approved service agency shall provide for the maintenance and operation of an accounting system that meets the Department's requirements.~~

~~B. The community centered board or program approved service agency shall submit financial reports in a format and manner prescribed by the Department, including but not limited to, an annual financial statement prepared in accordance with generally accepted accounting principles and Departmental policies.~~

~~**8.603.7 AUDITS, FINANCIAL INFORMATION AND BUDGET INFORMATION**~~

~~A. Each designated Community Centered Board is subject to the requirements of the "Colorado Local Government Audit Law," see section 29-1-601 et seq., C.R.S.~~

~~1. Each Community Centered Board shall require the person or entity that performs financial audits of the Community Centered Board to present and discuss the results of the audit to the board of directors not less than once each year at a regularly scheduled meeting of the board of directors.~~

~~2. Each completed financial audit shall be posted on The Community Centered Board's website, in a place that allows access to the public in a clear, accessible, easily operated, and uncomplicated manner.~~

~~3. Each completed financial audit shall be posted on the website of the Community Centered Board within thirty days of acceptance by the corporation's board of directors. Completed audits shall remain posted on the website for no less than three fiscal years.~~

~~B. Each Community Centered Board is subject to a performance audit by the state auditor in accordance with Section 25.5-10-209(4), C.R.S. The Community Centered Board shall cooperate with the performance audit by the state auditor.~~

~~C. Each Community Centered Board shall post on their website the most current Form 990 that has been filed with the internal revenue service. Form 990 shall be posted no later than thirty days following the filing of the form with the Internal Revenue Service. Each Form 990 shall remain posted on the website for a minimum of three fiscal years.~~

~~D. The Community Centered Board shall make the following information available upon request, not later than five business days after the request is made:~~

~~1. The annual budget of the Community Centered Board for each calendar or fiscal year, as applicable, not later than thirty days after final approval of the budget by the board of directors of the Community Centered Board;~~

~~2. An annual summary of all revenues and expenditures of the Community Centered Board as have been appropriated by the state concerning capacity building, Family Support Services, State General Fund Supported Living Services, and State General Fund Early Intervention that is calculated by September 30 of each year for the prior year, as applicable; and~~

~~3. A description of the policies and procedures it follows to track, manage, and report its financial resources and transactions, which policies and procedures are also known and may be referred to as its "financial controls".~~

~~**8.603.8 INSURANCE AND LIABILITY COVERAGE**~~

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A. Community centered boards and program approved service agencies shall maintain, in force at all times, a comprehensive general liability insurance policy, issued by a company authorized to do business in Colorado in an amount acceptable to the Department as specified by contract for total injuries or damages arising from any one incident, for bodily injuries or damages.

B. Program approved service agencies shall maintain or require to be maintained in force at all times, comprehensive general liability insurance coverage for services that are provided directly by the agency or through contract.

C. The community centered board or a program approved service agency shall obtain and maintain at all times a fidelity bond in an amount acceptable to the Department covering the activities of its officers or agents.

D. Adequate insurance coverage, as required by state law or regulation, for the protection of vehicle fleets, riders and operating personnel, must be provided by anyone transporting persons with disabilities.

E. A community centered board or a program approved service agency managing personal needs funds shall purchase and maintain a surety bond in an amount specified by the Department, or provide an irrevocable letter of credit in the same amount, made payable to the state, to protect the personal needs of the person receiving services.

8.603.9 PERSONNEL AND CONTRACTOR ADMINISTRATION

A. Community centered boards and program approved service agencies shall establish qualifications for employees and contractors (Host Home and other providers) and maintain records documenting the qualifications and training of employees and contractors who provide services pursuant to these rules and regulations.

B. The community centered board or service agency may, in accordance with section 27-90-110, C.R.S., conduct background checks and reference checks prior to employing staff providing supports and services and contracting with Host Home and other providers.

C. The community centered board in its role as support coordinating agency, as defined in section 8.609.1, shall have screening procedures for individual providers who are not agency employees and for other entities providing services and supports.

D. The community centered board and program approved service agency shall have an organized program of orientation and training of sufficient scope for employees and contractors to carry out their duties and responsibilities efficiently, effectively and competently. The program shall, at a minimum, provide for:

1. Extent and type of training to be provided prior to employees or contractors providing supports and services having unsupervised contact with persons receiving services;

2. Training related to health, safety and services and supports to be provided within the first ninety (90) days for employees and contractors; and,

3. Training specific to the individual(s) for whom the employees or contractors will be providing services and supports.

E. Community centered boards shall ensure that individuals who are hired to fulfill the duties of case management services on or after October 8, 2021 meet the requirements in Section 8.519.5.B.

F. All employees and contractors, not otherwise authorized by law to administer medication, who assist and/or monitor persons receiving services in the administration of medications or the filling of medication reminder systems shall have passed a competency evaluation offered by an approved training entity, as defined in 6 CCR 1011-1, Chapter 24, *et seq*.

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8.603.10 PURCHASE OF SERVICE RATES

A. Annually the Department shall make available a schedule of program rates to be used to purchase non-community centered board specific authorized services for persons with developmental disabilities. The established rates shall be based upon the annual appropriation from the General Assembly, the Department's determination of approved program cost and the 5% local match.

B. Annually, the community centered board shall make available a schedule of program rates and/or rate ranges used in their designated service area to purchase authorized services for persons with developmental disabilities.

C. Administration of community centered board Purchase of Service Rates shall comply with the following:

1. Pursuant to section 25.5-10-206(5), C.R.S., the following rules are provided for the purpose of delineating rates to be used by community centered boards for purchase of services from service agencies for persons receiving services for whom funds have been made available pursuant to section 25.5-10-206(5), C.R.S.

2. The community centered board is authorized to negotiate specific program rates for purchasing services from service agencies. The community centered board must maintain written documentation on how rates were established and paid, and an audit trail of provider expenses to support payments and future rate negotiations. The parameters to be followed in negotiating rates are as follows:

a. Rates must be consistent with efficiency, economy and quality of care.

b. The policy and methods used in setting payment rates must be in writing and consistently applied to all providers including the community centered board as provider.

c. Documentation of payment rates must be maintained and made available upon request.

d. Providers must be given sufficient information concerning the service obligations to assist them in developing cost effective and efficient rate proposals.

3. When a community centered board proposes to charge fees to service agencies for services, the following must be complied with:

a. The board of directors must approve all plans to charge service agencies;

b. The community centered board must provide the service agency with a written description for each service provided and the amount of the proposed fee for each service;

c. The proposed fee to service agencies cannot be established to pay for services otherwise reimbursed, as determined by the Department;

d. Any proposed fee by community centered boards related to managing the billing process must meet the following criteria:

1) The fee must relate to the cost of processing billings;

2) Not be related on a percentage or other basis to the amount that is billed or collected; and,

3) Not be dependent upon the collection of payment;

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e. Negotiated fees between community centered boards and service agencies will not be deducted from any payments for services; and,

f. The community centered board will provide the service agencies with statements for services delivered.

4. The community centered board shall establish procedures and reasonable timeframes that provide the opportunity for a service agency to protest the proposed fee charges to the community centered board, and for a timely written response.

5. The community centered board shall inform the service agency of the opportunities to appeal the decision to the Department; and,

6. The community centered board shall submit a copy of all protests and subsequent proceedings to the Department.

8.604 DUE PROCESS AND CONFIDENTIALITY

8.604.1 RIGHTS OF PERSONS RECEIVING SERVICES

A person receiving services has the same legal rights and responsibilities guaranteed to all other individuals under the federal and state constitutions and federal and state laws including, but not limited to, those contained in section 25.5-10, C.R.S., unless such rights are modified pursuant to state or federal law.

8.604.2 PROCEDURAL REQUIREMENTS REGARDING RIGHTS

A. The policies and procedures of community centered boards,and program approved service agencies and regional centers otherwise referred to as "agencies" must, at a minimum, provide that each person receiving services has the rights contained in Sections 25.5-10-218 through 231, C.R.S.

B. Persons receiving services shall have the right to read or have explained any rules or regulations adopted by the Department and policies and procedures of the community centered board, program approved service agency or regional center pertaining to such persons' activities, services and supports, or to obtain copies of section 25.5-10, C.R.S., rules, policies or procedures at no cost or at a reasonable cost in accordance with section 24-72-205, C.R.S.

C. Agencies shall inform persons receiving services, parents of minors, guardians and authorized representatives of the rights provided in section 25.5-10, C.R.S., and:

1. Agencies shall provide a written and verbal summary of rights and a description of how to exercise them, at the time of eligibility determination, at the time of enrollment, and when substantive changes to services and supports are considered through the Individualized Planning process.

2. The information shall be provided in a manner that is easily understood, verbally and in writing, in the native language of the person, or through other modes of communication as may be necessary to enhance understanding.

3. Agencies shall provide assistance and ongoing instruction to persons receiving services in exercising their rights.

D. No person receiving services, his/her family members, guardian or authorized representatives, may be retaliated against in their receipt of services or supports or otherwise as a result of attempts to advocate on their own behalf.

E. Employees and contractors must be made aware of the rights of persons receiving services and procedures for safeguarding these rights.

8.604.3 SAFEGUARDING THE RIGHTS OF PERSONS RECEIVING SERVICES

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~~A. An individual's rights may be suspended only to protect the individual from endangering such person, others, or property. Rights of an adult person receiving services may be suspended only by a developmental disabilities professional in a manner which will promote the least restriction on the person's rights and in accordance with rules and regulations herein or by a court order. Additionally, in the case of a minor, the parent(s) or guardian must approve suspension of any rights which may pertain to the minor.~~

~~1. When suspension of an individual's rights is under consideration, the rights to be affected shall be specifically explained to the individual with notice as defined in section 8.600.4 of these rules of such proposed activity given to the appropriate parties.~~

~~2. When a right is proposed to be suspended, it is reviewed by the individual's interdisciplinary team and, if suspended, is documented in the Individualized Plan. The person's Individualized Plan must include a statement of what services and supports are required and plans for implementing such services and supports in order to assist the person to the point that suspension of rights is no longer needed. This plan shall meet the requirements of Sections 8.607 and 8.608.~~

~~3. When a right has been suspended, the continuing need for such suspension shall be reviewed by the individual's interdisciplinary team at a frequency decided by the team, but not less than every six months.~~

~~a. Such review shall include the original reason for suspension, current circumstances, success or failure of programmatic intervention, and the need for continued suspension or modification.~~

~~b. Restoration of affected rights shall occur as soon as circumstances justify.~~

~~4. At the time a right is suspended, such action shall be referred to the Human Rights Committee for review and recommendation. Such review shall include an opportunity for the person who is affected, parent of a minor, guardian or authorized representative, after being given reasonable notice of the meeting, to present relevant information to the Human Rights Committee.~~

~~5. Emergency action may be taken by a developmental disabilities professional, specifically designated for this purpose, by the director of the community centered board, program approved service agency or regional center to suspend the right(s) of a person receiving services if such action is imminently necessary to protect the health and safety of the person, others, or property When such emergency action is necessary, the least intrusive means of right(s) suspension shall be utilized in order to protect the health and safety of the person or others, or property, and the following requirements must be adhered to:~~

~~a. The person assigned case management responsibility pursuant to section 8.607.1.E, must be notified of the right(s) suspension within 24 hours;~~

~~b. The suspended right(s) shall be specifically explained to the individual and notice as defined in section 8.600.4, sent to the appropriate parties within 24 hours of the suspension of the right(s); and,~~

~~c. Immediately initiate the provisions of section 8.604.3.A.2 through 4.~~

~~B. Suspension from Services and Supports~~

~~1. The community centered board shall ensure that an interdisciplinary team is convened, to review the cause for suspension and to revise the Individualized Plan. If the suspension is part of a restrictive program meeting requirements of section 8.608.2 such a meeting may not be necessary.~~

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2. Provisions for temporary suspension of specific services or supports received by an individual may be made if, in the opinion of the community centered board, program approved service agency or regional center, a person receiving services has demonstrated a serious physical threat to the health or safety of the person or others and such is necessary to protect the health or safety of the person or others.

3. Suspension is considered temporary in nature, may not be used to effect termination from services or supports, and must be fully documented in the record of the person receiving services including provisions of when original services or supports will resume.

4. Suspension of specific services or supports received by an individual shall not relieve the community centered board, program approved service agency or regional center of responsibility to provide case management services, modified services or supports that may be provided in an alternative setting, and continued habilitation and planning to facilitate the person's return to the original services or supports, if appropriate.

5. Services and supports may not be suspended if such suspension would place such person at risk of loss of a place of abode.

6. The Department may authorize suspension of services or supports pending the outcome of a dispute resolution process on termination and enter orders regarding the responsibility to provide alternative services during this time period. The program approved service agency or community centered board may request such authorization by following the process for emergency proceedings outlined at section 8.605.4.

8.604.4 USE OF AN AUTHORIZED REPRESENTATIVE

A. Persons who are eligible for services and supports, the parent or guardian of a minor, or legal guardian of an adult, shall be informed at the time of enrollment and at each annual review of the Individualized Plan that they may designate an authorized representative.

The designation of an authorized representative must occur with informed consent of the person receiving services, or the parent or guardian of a minor, or legal guardian of an adult.

B. Such designation shall be in writing and shall specify the extent of the authorized representative's involvement in assisting the person receiving services in acquiring or utilizing services or supports available pursuant to section 25.5-10, C.R.S, and in protecting their rights.

C. The written designation of an authorized representative shall be maintained in the record of the person receiving services.

D. The person receiving services may withdraw their designation of an authorized representative at any time.

8.605 DISPUTE RESOLUTION PROCEDURES

8.605.1 DISPOSITION OF PETITIONS FOR DECLARATORY ORDERS

The Executive Director of the Department or designee may entertain petitions for declaratory orders in accordance with section 24-4-105(11), C.R.S., when a controversy or uncertainty exists involving the application of these rules or the Developmental Disability Act (section 25.5-10 C.R.S.), to a particular set of circumstances between the parties. A petition may be filed when a process for resolving the controversy is not otherwise provided in these rules and an interpretation of the law will clarify the intent of the law in a particular situation. Thus the petitioner is asking for the Executive Director to "declare" the rights or status of the parties under the law that is at the heart of controversy.

A. Any petition filed pursuant to this rule shall set forth the following:

1. The name and address of the petitioner;

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2. The statute, rule or order to which the petition relates;

3. A concise statement of all of the facts necessary to show the nature of the controversy or uncertainty; and,

4. All parties directly involved in the subject matter of the petition as known to the petitioner.

B. If the Executive Director or designee decides to rule on the petition, the following procedures shall apply:

1. The Executive Director or designee shall provide notice of the petition and an opportunity to respond to the petition to all parties noted by the petitioner or otherwise known to the Department to be directly interested in the petition;

2. The Executive Director or designee may rule upon the petition based solely upon the facts presented in the petition and response. In such a case:

Any ruling of the Department will apply only to the extent of the facts presented in the petition and the response;

3. The Executive Director or designee may request the petitioner or any involved party to submit additional information, or file a written brief, memorandum, or statement of position;

4. The Executive Director or designee may rule upon the petition without a hearing or may set the petition for hearing, upon due notice to all parties to obtain additional facts or information; and,

5. The ruling of the Department shall be binding upon all parties to the matter.

8.605.2 DISPUTES BETWEEN INDIVIDUALS AND PROGRAM APPROVED SERVICE AGENCIES

A. Every community centered board, regional center and program approved service agency shall have procedures which comply with requirements as set forth in these rules and section 25.5-10-212, C.R.S., for resolution of the following disputes involving individuals:

1. The applicant is not eligible for services or supports;

2. The person is no longer eligible for services or supports;

3. Services or supports are to be terminated; or,

4. Services set forth in the IP which are to be provided, or are to be changed or reduced, or denied.

B. The procedure shall contain an explanation of the process to be used by persons receiving services or applicants for services or parents of a minor, guardians and/or authorized representatives in the event that they are dissatisfied with the decision or action of the community centered board, regional center or program approved service agency.

C. The dispute resolution procedure shall be stated in writing, in English. Interpretation in native languages other than English and through such modes of communication as may be necessary shall be made available upon request.

1. The procedure shall be provided, orally and in writing, to all persons receiving services or applicants for services and parents of a minor, guardian, and/or authorized representative at the time of application, at the time the individualized plan is developed, any time changes in the plan are contemplated, and upon request by the above named persons.

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2. The procedure shall state that use of the dispute resolution procedure shall not prejudice the future provision of appropriate services or supports to the individual in need of and/or receiving services.

3. The procedure shall state that an individual shall not be coerced, intimidated, threatened or retaliated against because that individual has exercised his or her right to file a complaint or has participated in the dispute resolution process.

D. The procedure of the community centered board, regional center or the program approved service agency shall stipulate that notice of action proposed as defined in section 8.600.4 shall be provided to the person receiving services/applicant, and to the person's parents if a minor, guardian and authorized representative at least fifteen (15) days prior to the date actions enumerated in section 8.605.2.A become effective.

The above named persons may dispute such action(s) by filing a complaint with the agency initiating the action. Upon such complaint, the procedures set forth in section 8.605.2.E and the following provisions shall be initiated.

E. The procedure of the community centered board, regional center and program approved service agency shall provide the opportunity for resolution of any dispute through an informal negotiation process which may be waived only by mutual consent.

Mediation could be considered as one means to informal negotiation if both parties voluntarily agree to this process.

F. The opportunity for resolution of a dispute through informal negotiation shall include the scheduling of a meeting of all parties or their representatives within fifteen (15) days of the receipt of the complaint.

G. After opportunities for informal negotiation of the dispute have been attempted or mutually waived, either party may request that the dispute resolution process set forth in section 8.605.2.H and the following provisions shall be initiated.

Parent(s) or guardian of a minor, age birth to three years, may utilize the dispute resolution process specified under the requirements of the Procedural Safe Guards for early intervention services pursuant to the Individuals with Disabilities Education Act.

H. The dispute resolution procedures of the community centered board, regional center or program approved service agency shall, at a minimum, afford due process by providing for:

1. The opportunity of the parties to present information and evidence in support of their positions to an impartial decision maker. The impartial decision maker may be the director of the agency taking the action or their designee. The impartial decision maker shall not have been directly involved in the specific decision at issue;

2. Timely notification of the meeting (at least ten days prior) to all parties unless waived by the objecting parties;

3. Representation by counsel, authorized representative, or another individual if the objecting party desires;

4. The opportunity to respond to or question the opposing position;

5. Recording of the proceeding by electronic device or reporter;

6. Written decision within fifteen (15) days of the meeting setting forth the reasons therefore;

7. Notification that if the dispute is not resolved, the objecting party may request that the Executive Director of the Department or designee review the decision; and,

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8. Notification to the Department by the community centered board, regional center or program approved service agency of all disputes proceeding according to section 8.605.2.H and the determination made thereon.

I. The dispute resolution procedure of the Department shall be as follows:

1. A request to the Executive Director of the Department to review the outcome of the dispute resolution process shall be submitted to the Department within fifteen (15) working days from which the written decision was postmarked;

2. The request for review shall also contain a statement of the matters in dispute and all information or evidence which is deemed relevant to a thorough review of the matter. The community centered board, regional center or the program approved service agency or other party shall be afforded the opportunity likewise to respond within fifteen (15) working days;

3. The Executive Director of the Department or designee shall have the right to additional information and may request oral argument or a hearing if deemed necessary by the Executive Director or designee to render a decision;

4. The Executive Director of the Department or designee shall provide a de novo review of the dispute and shall render a decision within ten (10) working days of the submission of all relevant information; and,

5. The decision of the Executive Director of the Department shall constitute final agency action on the dispute.

J. No person receiving services may be terminated from services or supports during the dispute resolution process unless the Department determines an emergency situation, as meeting the criteria set forth in section 8.605.4 exists.

8.605.3 DISPUTES BETWEEN DEPARTMENT AND COMMUNITY CENTERED BOARD OR DEPARTMENT AND PROGRAM APPROVED SERVICE AGENCY

A. Pursuant to section 25.5-10-208(2)(c), C.R.S., the following shall apply in the event that the terms of a contract between the Department and a community centered board or program approved service agency are disputed by either party:

1. The community centered board or program approved service agency shall notify the Manager of the Office of Community Living of the circumstances of the dispute.

a. The parties shall informally meet at a mutually agreeable time to attempt resolution.

b. If the dispute cannot be resolved through this informal process then the formal process at section 8.605.3.A.2 shall be used.

2. The community centered board or program approved service agency shall submit a written request for formal dispute resolution to the Department.

a. The request shall state the specific grounds for the dispute.

b. It shall include all available exhibits, evidence, arguments, and documents believed to substantiate the protest, and the relief requested.

3. The Department may request additional information deemed necessary to resolve the dispute.

4. Within fifteen (15) working days following the receipt of written materials and additional requested information, the Department shall respond to the request by issuing a written decision, which shall be inclusive of the reasons for the decision.

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5. A copy of the documentation presented or considered, the decision made and the contract shall be maintained in the files of the Department.

6. The Department's decision shall represent final agency action on the disputed issue.

B. Notwithstanding the dispute, the community centered board or program approved service agency shall honor all contractual obligations entered into in its contract with the Department. No agency shall have its contract terminated pending resolution of a contractual dispute, unless necessary for the preservation of public health, safety or welfare, as determined pursuant to section 8.605.4.

C. Nothing in this procedure shall prohibit the Department from initiating action to revoke designation of a community centered board or program approval of a service agency based on evidence presented in the request for Departmental intervention or during its review.

8.605.4 EMERGENCY PROCEEDINGS

A. The Department retains the authority to enter emergency orders, when necessary, to preserve the health, safety or welfare of the public or of persons receiving services, including, but not limited to, situations that:

1. Are ongoing or likely to recur if not promptly corrected or otherwise resolved and, likely to result in serious harm to the individual or others; or,

2. Arise out of a service provider's discontinuance of operation generally, or discontinuance of services to a particular individual because the service agency is unable to ensure that person's safety or the safety of others.

B. The party requesting the Department to enter an emergency order shall submit all relevant documentation to the Department to which the opposing party shall have the opportunity to respond.

C. The Department may request additional information as needed and shall determine the timeframes for the submission.

D. In addition to ruling on the request for emergency order, the Department may review the substantive issues involved in the dispute and determine the required course of action.

8.605.5 GRIEVANCE/COMPLAINT PROCESS

A. Every community centered board, regional center and program approved service agency shall have procedures setting forth a process for the timely resolution of grievances or complaints of the person receiving services, parents of a minor, guardian and/or authorized representative, as appropriate. Use of the grievance procedure shall not prejudice the future provision of appropriate services or supports.

B. The procedure shall be provided, orally and in writing, to all persons receiving services, the parents of a minor, guardian and/or authorized representative, as appropriate, at the time of admission and at any time that changes to the procedure occur.

C. The grievance procedure shall, at a minimum, include the following:

1. Who within the agency will receive grievances;

2. Identification of support person(s) to assist in the submission of a grievance;

3. An opportunity for individuals to come together in order to attempt finding a mutually acceptable solution. This could include the use of mediation if both parties voluntarily agree to this process;

4. Timelines for the resolution of the grievance;

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5. Consideration by the agency director or designee if the grievance cannot be resolved at a lower level; and,

6. No individual shall be coerced, intimidated, threatened or retaliated against because the individual has exercised his or her right to file a grievance or has participated in the grievance process.

8.606 CONFIDENTIALITY

8.606.1 GENERAL PROVISIONS OF INFORMATION PERTAINING TO PERSONS SEEKING OR RECEIVING SERVICES:

A. Identifying information regulated by this rule is any information which could reasonably be expected to identify the person seeking or receiving services or their family or contact persons, including, but not limited to, name, Social Security number, Medicaid number, household number or any other identifying number or code, street address, and telephone number, photograph, or any distinguishing mark. Identifying numbers assigned and used internally within a single agency shall be excluded from this regulation.

B. The Department, Developmental Disabilities Services, regional centers, community centered boards, and program approved service agencies are hereinafter referred to as "agencies," within this section.

C. At the time of eligibility determination and enrollment, the person, parent of a minor, guardian and/or other person acting as an advisor to the person must be advised of the type of information collected and maintained by the agency, and to whom and where it is routinely disclosed.

D. This rule applies to confidential information in any format including, but not limited to, individual records, correspondence or other written materials, verbal communication, photographs, and electronically stored data.

E. The records and all other documentation or correspondence concerning persons seeking or receiving services are the property of the agency which is responsible for maintaining and safeguarding their contents.

F. All written authorizations referenced within this chapter must be:

1. Signed and dated;

2. For a specified time period;

3. Specific as to the information or photograph to be disclosed and the intended use of such information or photograph; and,

4. Specific as to whom it will be disclosed.

G. Authorizations may be revoked in writing or verbally at anytime by the person who provided the authorization.

8.606.2 DISCLOSURE OF CONFIDENTIAL INFORMATION

A. Disclosure of confidential information shall be limited to:

1. The person seeking or receiving services, parent of a minor, or guardian.

2. Persons or entities having written authorization signed by the person seeking or receiving services, parent of a minor, or guardian.

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3. The authorized representative of the person seeking or receiving services as defined in section 25.5-10-202(1), C.R.S., if access to confidential information is within the scope of their authority.

4. Qualified professional personnel of community centered boards, regional centers and other service agencies including boards of directors and Human Rights Committee members to the extent necessary for the acquisition, provision, oversight, or referral of services and supports.

5. To the Department or its designees as deemed necessary by the Executive Director to fulfill the duties prescribed by Title 25.5, Article 10 of Colorado Revised Statutes.

6. To the extent necessary, qualified professional personnel of authorized external agencies whose responsibility it is to license, to accredit, to monitor, to approve or to conduct other functions as designated by the Executive Director of the Department.

7. Physicians, psychologists, and other professional persons providing services or supports to a person in an emergency situation which precludes obtaining consent in such an instance:

   a. Documentation of this access shall be entered into the person's record.

   b. This documentation shall contain the date and time of the disclosure, the information disclosed, the names of the persons by whom and to whom the information was disclosed, and the nature of the emergency.

8. The court or to persons authorized by an order of the court, issued after a hearing, notice of which was given to the person, parents of a minor or legal guardian, where appropriate, and the custodian of the information.

9. Other persons or entities authorized by law; and,

10. The entity designated as the protection and advocacy system for Colorado pursuant to 42 U.S.C. 604 when:

   a. A complaint has been received by the protection and advocacy system from or on behalf of a person with a developmental disability; and,

   b. Such person does not have a legal guardian or the state or the designee of the state is the legal guardian of such person.

B. Nothing in this regulation should be taken to construe that a person or entity who is authorized to access confidential information regarding an individual per section 8.606.2.A can access any and all confidential information available regarding that individual. Disclosure of confidential information must be limited to those aspects of that information which are necessary to performing the duties of that person or entity requiring access. The person seeking or receiving services, parent of a minor, or guardian may access any and all aspects of that person's record. The authorized representative of a person may access those aspects of a person's record which are within the scope of their authority.

8.606.3 SAFEGUARDING RECORDS

A. Records pertaining to persons seeking or receiving services shall be maintained in accordance with these rules and other federal and state regulations and accreditation standards. Where no superseding regulation or policy applies, records may be purged and destroyed per agency policy.

B. An individual designated by the agency shall be responsible for the record at all times during the examination of the record by entities other than employees of that agency.

C. Records shall be made available for review at the agency to authorized persons within a reasonable period of time as negotiated by the agency and the party seeking access.

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D. At no time may a person examining a record remove anything from it or otherwise make changes in it, except as delineated below:

1. If the person seeking or receiving services, parent of a minor, guardian or authorized representative, if within the scope of his/her authority, objects to any information contained in the record, he/she may submit a request for changes, corrections, deletions, or other modifications.

2. The person seeking or receiving services, parent of a minor, guardian or authorized representative shall sign and date the request.

3. The agency administrator will make the final determination regarding the request and will notify the requesting party of the decision.

4. If the agency administrator denies the request, then the requestor has the right to have a statement regarding their request entered into the record.

E. Records or portions of records may be photocopied or otherwise duplicated only in accordance with written agency procedures, and any fee for duplication shall be reasonable pursuant to section 24-72-205, C.R.S. A person receiving services is entitled to one free copy of any information contained in his/her record.

8.607 CASE MANAGEMENT SERVICES

Case management service for Individuals with Intellectual and Developmental Disabilities HCBS waivers shall be provided pursuant to Section 8.519.1 through 8.519.23.

8.607.1 ADMINISTRATION

A. Community Centered Boards and regional centers shall be responsible to maintain sufficient documentation of case management activities performed and to support billings.

B. Community Centered Boards shall be responsible to maintain or have access to information about public and private, state and local services, supports and resources which may be available for persons with developmental disabilities, and shall make such information available to persons eligible for services and supports and authorized persons inquiring upon their behalf.

C. Each Community Centered Board and regional center, as appropriate, shall establish agency procedures sufficient to execute case management services according to the provisions of these rules and regulations.

D. Case management services shall be a direct responsibility of the executive level of the Community Centered Board or regional center organization and are separate from the delivery of services and supports unless otherwise approved by the Department.

E. The Community Centered Board or regional center shall assign one (1) primary person who ensures case management services are provided on behalf of the person receiving services across all program, professional and agency lines. Reasonable efforts shall be made by the Community Centered Board or regional center to include the preferences of the eligible person in this assignment.

8.607.2 DETERMINATION OF DEVELOPMENTAL DISABILITY

A. Any person, his/her legal guardian, parent(s) of a minor or such person(s) authorized by law may submit a written request for a determination of whether the applicant has a developmental disability.

B. A determination of developmental disability does not constitute a determination of eligibility for services or supports. The Community Centered Boards shall determine whether a person has a

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developmental disability and therefore may be eligible to receive services and supports pursuant to Sections 25.5-10-202(2) and 211, C.R.S., in accordance with criteria as specified by the Department.

Eligibility for Medicaid funded programs specific to persons with developmental disabilities shall be determined pursuant to the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 C.C.R. 2505-10).

C. The developmental disability determination shall be made according to Department procedures, which shall identify the qualifications of person(s) making such a determination.

D. A request for determination of developmental disability shall be submitted to the Community Centered Board in the designated service area where the person resides, including temporary residence such as incarceration or hospitalization.

E. At the time of request, the Community Centered Board shall:

1. Provide the applicant any required forms and a list of the minimum required documents and information necessary for the determination of developmental disability; and,

2. Provide the applicant with information on where to obtain testing for the level of intellectual functioning and adaptive behavior, if requested. The responsibility for obtaining such assessments shall be with the applicant and/or legal guardian.

F. The applicant and/or legal guardian shall provide all documentation and information necessary for the determination of developmental disability within ninety (90) calendar days of the request.

1. The Community Centered Board may request additional documentation and/or information, as needed, to complete the determination of developmental disability.

2. The applicant and/or legal guardian may have additional assessments completed and submitted to the Community Centered Board for consideration.

G. If the applicant and/or legal guardian has not provided the documentation and information necessary for the determination within ninety (90) calendar days of the request, the Community Centered Board shall:

1. Close the request and notify the applicant in writing according to the procedures established at Section 8.607.2.L.4; or,

2. The Community Centered Board may, at the request of the applicant and/or legal guardian, extend the deadline for providing the necessary documentation and information by up to an additional ninety (90) calendar days.

a. In no case shall the deadline for providing the necessary documentation and information exceed one hundred eighty (180) calendar days.

b. The Community Centered Board shall provide a written update to the applicant no less than every ninety (90) calendar days until a determination of developmental disability is completed or the request is closed.

c. If the extended deadline for providing the necessary documentation and information has expired and there is still insufficient information to make a determination of developmental disability, the Community Centered Board shall close the request and notify the applicant and/or legal guardian in writing according to the procedures established at Section 8.607.2.L.4.

H. For all applicants, the Community Centered Board shall enter into the Department's designated data system and shall permanently maintain a written and/or electronic record of the developmental disability determination on a Department prescribed form. The record, at a minimum, shall include:

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1. The name of the applicant;

2. The applicant's date of birth;

3. The date of the determination of developmental disability;

4. A description of the rationale for the developmental disability determination including, at minimum, assessment scores and diagnoses;

5. The name(s) and title(s) of the person(s) involved in making the determination.

I. All information and assessments used to determine a developmental disability shall be current so as to accurately represent the applicant's abilities at the time of determination.

1. Assessments of adaptive behavior shall have been completed within three (3) years of the request.

2. Assessments of intellectual functioning shall have been completed as follows:

a. If an individual is between five (5) and eighteen (18) years of age, at least one intellectual assessment shall have been completed to determine the individual's impairment of general intellectual functioning; or,

b. If an individual is eighteen (18) years of age or older and there is only one intellectual assessment available to determine the individual's impairment of general intellectual functioning, the assessment shall have been completed when the individual was at least eighteen (18) years of age and shall have been completed within ten (10) years of the request; or,

c. If there is historical pattern of consistent scores, based on two (2) or more intellectual assessments, that demonstrates an impairment of general intellectual functioning, the assessments may be used regardless of the individual's age at the time of determination.

3. An established neurological condition shall be documented as follows:

a. A diagnosed neurological condition shall be determined by a licensed medical professional practicing within the scope of his/her license; or,

b. If a specific diagnosis is not possible, a written statement from a licensed medical professional, practicing within the scope of his/her license, or a licensed psychologist may be used as long as there is a documented effort to determine a diagnosis and the available assessment information reasonably supports a conclusion that a neurological impairment is present.

4. The effects of mental illness or physical or sensory impairment must be considered to determine the extent to which such impairments are the sole contributing factor to the impairment of general intellectual functioning or limitations to adaptive behavior.

J. Prior to July 1, 2015, the Community Centered Board shall make the determination of developmental disability within ninety (90) calendar days of the receipt of all necessary information. On or after July 1, 2015, the Community Centered Board shall make the determination of developmental disability within thirty (30) calendar days of the receipt of all necessary information.

K. The date of the developmental disability determination shall be the date that the Department prescribed form and all documentation and information necessary for the determination of developmental disability was received by the Community Centered Board.

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If a delay to the determination of developmental disability is due to the actions or inactions of the Community Centered Board, the original date of request shall be used.

L. The Community Centered Board making the developmental disability determination shall, in writing, notify the applicant or legal guardian, and the authorized person requesting the determination, if other than the applicant or legal guardian, and other such persons as designated by the applicant, of the decision. Such notification shall:

1. Be mailed to the person within seven (7) calendar days of the date of determination;

2. Be provided in such alternative means of communication as to reasonably ensure that the information has been communicated in an understandable form; and,

3. For persons determined to have a developmental disability, contain an explanation of the process that will occur and notice that, at a minimum, an Individualized Plan shall be developed upon enrollment into a developmental disability service;

4. For persons determined not to have a developmental disability or persons whose request is closed without the determination of a developmental disability, state the reasons for the determination or closure, and provide a written For persons determined not to have a developmental disability or persons whose request is closed without the determination of a developmental disability, state the reasons for the determination or closure, and provide a written Long-Term Care Notice of Action form in accordance with the provisions of Section 8.057 regarding the applicant's right to appeal the decision to the Office of Administrative Courts.

M. Applicants determined not to have a developmental disability may request a new determination of developmental disability at any time upon receipt of new or missing required information, and a new request date shall be established.

N. A determination of developmental disability shall be accepted by other Community Centered Boards, service agencies and regional centers.

O. A determination of developmental disability shall be permanent and shall not require renewal or review unless:

1. The interdisciplinary team determines that developmental disability services are no longer needed due to improvement in a person's condition and recommends a redetermination; or,

2. Information from a new evaluation becomes available which demonstrates sufficient improvement in a person's condition such that the determination should be reviewed.

8.607.3 SERVICE AND SUPPORT COORDINATION

A. Service and support coordination shall be the responsibility of the community centered boards and regional centers. Service and support coordination shall be provided in partnership with the person receiving services, the parents of a minor, legal guardian and public and private agencies to the extent such partnership is requested by these individuals. Persons receiving services who are their own guardians may also request their family or others to participate in this partnership.

B. Service and support coordination shall assist the eligible person to ensure:

1. An Individualized Plan is developed, utilizing necessary information for the preparation of the Individualized Plan and using the Interdisciplinary Team process;

2. Facilitating access to and provision of services and supports identified in the Individualized Plan;

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3. The coordination of services and supports identified in the Individualized Plan for continuity of service provision; and,

4. The Individualized Plan is reviewed periodically, as needed, to determine the results achieved, if the needs of the person receiving services are accurately reflected in the Individualized Plan, whether the services and supports identified in the Individualized Plan are appropriate to meet the person's needs and what actions are necessary for the plan to be achieved.

8.607.4 INDIVIDUALIZED PLAN (IP)

A. Under the coordination and direction of the community centered board or regional center, the Interdisciplinary Team (IDT) shall develop the Individualized Plan (IP).

B. There shall be at least ten (10) days written notice from the timestamped date given to all Interdisciplinary Team members prior to an Individualized Plan meeting unless waived by the person receiving services or guardian as necessary and desirable.

Every effort shall be made to convene the meeting at a time and place convenient to the person receiving services, their legal guardian, authorized representative and parent(s) of a minor. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or memberclient (e.g. natural disaster, pandemic, etc.).

C. The community centered board, and service agency or regional center as applicable, shall make available to the interdisciplinary team for each person receiving services such information as is necessary to develop the Individualized Plan.

D. The Individualized Plan shall:

1. Identify the unique strengths, abilities, preferences, desires, and needs of the person receiving services and their family, as appropriate;

2. Identify the specific services and supports appropriate to meet the needs of the eligible person, and family, as appropriate;

3. Document decisions made through the interdisciplinary team planning process including, but not limited to, rights suspension, the existence of appropriate services and supports, the actions necessary for the plan to be achieved, including which services and supports will be addressed through the development of an Individual Service and Support Plan (ISSP). The services and supports funded by the Department to be provided shall be described in sufficient detail as to provide for a clear understanding by the service agency(ies) of expected responsibilities and performance;

4. Describe the results to be obtained from the provision of services and supports identified in the Individualized Plan;

5. Document the authorized services and supports funded by the Department and the projected date of initiation;

6. Identify a contingency plan for how necessary care for medical purposes will be provided in the event that the person's family or caregiver is unavailable due to an emergency situation or to unforeseen circumstances. “Medical purposes” refers to a medical condition that places the individual at risk of not surviving, and that requires the support of persons qualified to

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address the specific medical needs of the person receiving services. Such medical conditions include, but are not limited to:

a. Dependency on technology, such as respirators, tracheotomy tubes, or ventilators;

b. Monitoring of medical equipment, such as a heart monitor; or,

c. Uncontrolled seizures for which a response while receiving services is likely.

A contingency plan is not needed for non-medical purposes or if the person receiving services does not have specific medical needs that would place him/her at risk because of the unavailability of the family or service provider. The development of a contingency plan in and of itself does not create an entitlement for services, for which none existed before.

7. Have a listing of the Interdisciplinary Team participants and their relationship to the person receiving services; and,

8. Contain a statement of agreement with the plan signed by the person receiving services or other such person legally authorized to sign on behalf of the person and a representative of the community centered board or regional center. The case manager may accept digital signatures on the agreement.

E. Copies of the Individualized Plan shall be disseminated to all persons involved in implementing the Individualized Plan including the person receiving services, their legal guardian, authorized representative and parent(s) of a minor, and the Department or others, as necessary and appropriate. If requested, copies shall be made available prior to the provision of services or supports; or within a reasonable period of time not to exceed thirty (30) days from the development of the Individualized Plan and in accordance with these rules.

F. The Individualized Plan shall remain in effect for a period not to exceed one year without review, and shall be reviewed and amended more frequently by the Interdisciplinary Team, as determined necessary and appropriate by Interdisciplinary Team members in order that the Individualized Plan accurately reflects the eligible person's current needs and circumstances. The community centered board or regional center shall coordinate the scheduling of such reviews.

8.607.5 OBTAINING SERVICES AND SUPPORTS

A. Each community centered board shall establish and maintain a system to disseminate a Request for Provider (RFP) for memberclients who are seeking a Program Approved Provider Agency and to refer the memberclient to approved providers who respond to the RFP.

B. Each community centered board shall establish one (1) waiting list for services and supports for eligible persons for whom funding from the Department is unavailable. This waiting list shall be maintained in an up-to-date, consolidated written form as specified by the Department and managed pursuant to the rules of the Colorado Department of Health Care Policy and Financing's Medical Assistance Staff Manual (10 C.C.R. 2505-10), and the guidelines of the Department regarding waiting lists for Developmental Disabilities Services.

8.607.6 MONITORING

Case Management AgenciesRegional centers shall be responsible to monitor the overall provision of services and supports authorized by the Department.

A. The frequency and level of monitoring shall meet the guidelines of the program in which the person is enrolled. At a minimum, monitoring shall include the following for each person:

1. The delivery and quality of services and supports identified in the Individualized Plan;

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2. The health, safety and welfare of individuals;

3. The satisfaction with services and choice in providers; and,

4. That the regional center's and service agency's practices promote a person's ability to engage in self-determination, self-representation and self-advocacy.

B. A review of overall services and supports provided on an agency and system level shall be conducted to determine:

1. The general satisfaction of persons in regard to services and supports received;

2. The general practices of service agencies regarding health, safety and welfare of persons receiving services;

3. Fiscal compliance related to the implementation of Individualized Plans; and,

4. The nature and frequency of complaints regarding a service agency.

8.607.8 MEDICAID PROGRAMS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

A. Regional Center Referral Process

1 A Client may be referred to a regional center for emergency short-term placement not to exceed ninety (90) days. Such referral shall be made as specified by the Colorado Department of Human Services (CDHS) and, at minimum, shall ensure that the CMA has exhausted all reasonable alternatives in an effort to procure or provide emergency services and supports in the Client's local community.

2. Clients may be referred to a regional center for long-term placement as specified by the CDHS. Such procedures shall include, but are not limited to:

A. The CMA responsible for case management services has notified the appropriate regional center and has involved the regional center in the evaluation process;

B. The CMA, Client, and the service planning team have reviewed and recommended placement;

C. All reasonable alternatives have been exhausted by the CMAto procure services and supports in the Client's local community and such efforts have been documented; and,

D. The Client or legal guardian is a resident of Colorado.

B. Nursing Facilities

For persons referred for a Preadmission Screening and Annual Resident Review (PASARR), the completion of the PASARR in accordance with the Department's guidelines, shall be the responsibility of the Community Centered Board in the area in which the person is physically residing, unless otherwise agreed upon by the Community Centered Boards affected.

8.608 SERVICE AND SUPPORT PLANNING, SUPPORTING PEOPLE WITH CHALLENGING BEHAVIOR, AND PROTECTIONS

Pursuant to section 25.5-10-101, C.R.S., these rules establish requirements for planning and providing humane services and supports in humane physical environments. These rules are designed to assist and guide the provision of services and supports within the best practices known to the Department, encourage the maintenance and continued development of best practices within community centered boards, service agencies, and regional centers, and to protect persons from abuse, mistreatment, neglect, and exploitation.

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All community centered boards, service agencies, and regional centers shall actively work to make available to each person with a developmental disability the full opportunity to be included in community life, make increasingly sophisticated and responsible choices, exert greater control over his or her life, establish and maintain relationships and a sense of belonging, develop and exercise their competencies and talents, and experience personal security and self respect.

These agencies shall also actively work to make available to each person the patterns and conditions of everyday life, which are consistent with those of persons without disabilities, including jobs and homes to the maximum extent possible. All services and supports offered will be appropriate to the chronological age of the person and shall take individual preferences into consideration.

8.608.1 SERVICE AND SUPPORT PLANNING AND DEVELOPMENT

A. Written Individual Service and Support Plans shall be developed by service agencies to address the prioritized needs for training (i.e., instruction, skill acquisition), habilitation and/or supports as developed by the interdisciplinary team in the Individualized Plan in such areas as personal, physical, mental and social development and to promote self-sufficiency and community inclusion.

1. Program approved service agencies providing comprehensive services shall develop Individual Service and Support Plans for all persons receiving services in accordance with the Individualized Plan.

2. Individual Service and Support Plans for support services shall be developed, as needed, to ensure that services and supports are provided consistently and reach the intended results, and as determined by the Interdisciplinary Team.

3. An Individual Service and Support Plan is not required for case management services, family support services, transportation services, or other such services as specified by the Department.

4. An Individual Service and Support Plan is required whenever a restrictive procedure is to be used. Any Individual Service and Support Plan including a restrictive procedure must meet the requirements outlined at section 8.608.2.

B. The purposes and content of the Individual Service and Support Plan document shall be to provide:

1. A written statement of the objective or result that the Individual Service and Support Plan is to accomplish;

2. A written explanation of the specific methodology, strategy or procedure that will be implemented;

3. A means for consistent implementation between the various service agencies providing services and supports provided for the person; and,

4. Criteria against which the effectiveness of the Individual Service and Support Plan shall be measured, the data to be collected, and timelines for reviews.

C. The development and implementation of the written Individual Service and Support Plan shall be the responsibility of the program approved service agency(ies) from which the person receives services or supports, and a copy shall be submitted to the community centered board or regional center. The person receiving service, guardian and/or authorized representative, as appropriate, shall be made aware that a copy of the Individual Service and Support Plan will be made available to them upon request. The CCB shall document the request in the Individualized Plan if asked to do so. If requested, the ISSP shall be provided within 30 days of the date given in the IP for it to be written.

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D. The Individual Service and Support Plan and subsequent reviews shall be written and become part of the master record.

E. When a person needs assistance with challenging behavior, including a person whose behavior is dangerous to himself, herself or others, or engages in behavior which results in significant property destruction, the program approved service agency in conjunction with other members of the person's interdisciplinary team shall complete a comprehensive review of the person's life situation including:

1. The status of friendships, the degree to which the person has access to the community, and the person's satisfaction with his or her current job or housing situation;

2. The status of the family ties and involvement, the person's satisfaction with roommates or staff and other providers, and the person's level of freedom and opportunity to make and carry out decisions;

3. A review of the person's sense of belonging to any groups, organizations or programs for which they may have an interest, a review of the person's sense of personal security, and a review of the person's feeling of self-respect;

4. A review of other issues in the person's current life situation such as staff turnover, long travel times, relationship difficulties and immediate life crises, which may be negatively affecting the person;

5. A review of the person's medical situation which may be contributing to the challenging behavior; and,

6. A review of the person's Individualized Plan and any Individual Service and Support Plans to see if the services being provided are meeting the individual's needs and are addressing the challenging behavior using positive approaches.

F. If any aspects of this review suggests that the person's life situation could be or is adversely affecting his or her behavior, these circumstances shall be evaluated by the interdisciplinary team, and specific actions necessary to address those issues shall be included in the Individualized Plan and/or Individual Service and Support Plan, prior to the use of any restrictive procedures to manage the person's behavior.

G. Issues identified in this comprehensive review that cannot be addressed by the interdisciplinary team should be documented in the Individualized Plan or Individual Service and Support Plan, and the community centered board or regional center administration should be notified of these issues and the present or potential effect they will have on the person involved.

8.608.2 INDIVIDUAL SERVICE AND SUPPORT PLAN (ISSP) INCLUDING A RESTRICTIVE PROCEDURE

A. When restrictive procedures, as defined in section 8.600.4, are recommended or used to change a person's challenging behavior, the following steps must be completed:

1. The program approved service agency in conjunction with other members of the person's interdisciplinary team shall complete a comprehensive review of the person's life situation;

2. The program approved service agency shall complete a functional analysis of the person's challenging behavior for review by the interdisciplinary team; and,

3. In conjunction with the interdisciplinary team, the program approved service agency shall prepare an Individual Service and Support Plan that explains the use of any restrictive procedure and includes, at a minimum:

a. A description of the behavior to be changed or improved, described when possible, in observable and measurable terms;

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b. Baseline data which demonstrates why the behavior has been targeted for change;

c. A description of the specific methodology and procedures that will be used to implement the Individual Service and Support Plan;

d. Identification of the person(s) who will monitor the implementation of the Individual Service and Support Plan;

e. A description of the behavior to be developed, if necessary and appropriate;

f. Identification of the person(s) who will implement the Individual Service and Support Plan and assurance that they have demonstrated competency in its implementation;

g. Criteria which will measure the effectiveness of the Individual Service and Support Plan;

h. Data to be collected; and,

i. Specific timelines for review.

4. The person receiving services, parents of a minor, or legal guardian shall grant informed consent for the use of the Individual Service and Support Plan with a restrictive procedure prior to its implementation.

8.608.3 REQUIREMENTS WHEN USING RESTRAINT

A. Physical or mechanical restraint can only be used by employees or contractors trained in its use, in an emergency situation, when alternatives have failed, and when necessary to protect the person from injury to self or others.

1. The individual shall be released from physical or mechanical restraint as soon as the emergency condition no longer exists.

2. Physical or mechanical restraint cannot be a part of an Individual Service and Support Plan and can only be used as an emergency or safety control procedure in accordance with these rules and regulations.

3. No physical or mechanical restraint of a person receiving services shall place excess pressure on the chest or back of that person or inhibit or impede the person's ability to breathe.

4. During physical restraint, the person's breathing and circulation shall be checked to ensure that these are not compromised.

5. Each community centered board,and program approved service agency, and regional center shall have written policies and procedures on the use of physical restraint exceeding fifteen (15) minutes. Such policies and procedures shall allow for physical restraint exceeding fifteen (15) minutes only when absolutely necessary for safety reasons and shall provide for backup by appropriate professional and/or agency staff.

6. Relief periods of, at a minimum, ten (10) minutes every one (1) hour shall be provided to an individual in mechanical restraint, except when the individual is sleeping. A record of relief periods shall be maintained.

7. An individual placed in a mechanical restraint shall be monitored at least every fifteen (15) minutes by employees or contractors trained in the use of mechanical restraint to ensure that the individual's physical needs are met and the individual's circulation is not restricted or airway obstructed. A record of such monitoring shall be maintained.

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B. Mechanical restraints used for medical purposes following a medical procedure or injury shall be authorized by a physician's order which shall be renewed every twenty-four (24) hours. Requirements of section 8.608.3.A applicable to mechanical restraint shall also apply.

C. Mechanical or physical restraints used for a diagnostic or other medical procedure conducted under the control of the agency (e.g., drawing blood by an agency nurse) shall be dually authorized by a licensed medical professional and agency administrator, and its use documented in the person's record.

8.608.4 REQUIREMENTS FOR EMERGENCY AND SAFETY CONTROL PROCEDURES

A. An Emergency Control Procedure is the unanticipated use of a restrictive procedure or restraint in order to keep the person receiving services and others safe.

1. Each Community Centered Board,and program approved service agency, and regional center shall have written policies on the use of emergency control procedures, the types of procedures which may be used, and requirements for staff training.

2. Behaviors requiring emergency control procedures are those which are infrequent and unpredictable.

3. Emergency control procedures shall not be employed as punishment, for the convenience of staff, or as a substitute for services, supports or instruction.

4. Within twenty-four (24) hours after the use of an emergency control procedure, the responsible staff person shall file an incident report. The incident report shall meet all requirements of Section 8.608.6.B and shall also include:

a. A description of the emergency control procedure employed, including beginning and ending times;

b. An explanation of why the procedure was judged necessary; and,

c. An assessment of the likelihood that the behavior that prompted the use of the emergency control procedure will recur.

5. Within three (3) days after use of an emergency control procedure, the Community Centered Board, case management agency or regional center, parent of a minor, guardian, and authorized representative if within the scope of his or her duties, shall be notified.

B. Safety control procedures must be developed when it can be anticipated that there will be a need to use restrictive procedures or restraints to control a previously exhibited behavior which is likely to occur again. The use of safety control procedures shall comply with the following:

1. Each Community Centered Board,and program approved service agency, and regional center shall have written policies on the use of safety control procedures, the types of procedures which may be used, and requirements for staff training;

2. When a safety control procedure is used, the service agency shall file an incident report within three (3) days with the Community Centered Board,or case management agency or regional center which meets all requirements of Section 8.608.6.B and the conditions associated with each use of a safety control procedure; and,

3. If the safety control procedure is used more than three times within the previous thirty (30) days, the person's interdisciplinary team shall meet to review the situation and to endorse the current plans or to prepare other strategies.

8.608.5 HUMAN RIGHTS COMMITTEES (HRC)

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A. Each community centered board and regional center shall establish at least one Human Rights Committee (HRC) as a third party mechanism to safeguard the rights of persons receiving services. The Human Rights Committee is an advisory and review body to the administration of the community centered board or regional center.

B. Such committee shall be constituted as required by section 25.5-10-209(2)h, C.R.S.

C. If a consultant to the community centered board, regional center, or service agency serves on the Human Rights Committee, procedures shall be developed by the community centered board or regional center and the Human Rights Committee related to potential conflicts of interest.

D. The community centered board and regional center shall orient members regarding the duties and responsibilities of the Human Rights Committee.

E. The community centered board and regional center shall provide the Human Rights Committee with the necessary staff support to facilitate its functions.

F. Each program approved service agency shall make referrals as required in rules and regulations for review by the Human Rights Committee(s) in the manner required by the community centered board or regional center.

G. The recommendations of the Human Rights Committee shall become a part of the community centered board's,or service agency's or regional center's record as well as a part of the individual's master record.

H. The Human Rights Committee shall develop operating procedures which include, but are not limited to, Human Rights Committee responsibilities for the committee's organization, the review process, and provisions for recording dissenting opinions of committee members in the committee's recommendations.

I. The Human Rights Committee shall establish and implement operating and review procedures to determine that the practices of the community centered board,and service agencies and regional centers are in compliance with section 25.5-10, C.R.S., are consistent with the mission, goals and policies of the Department,or community centered board or regional center, and ensure that:

1. Informed consent is obtained when required from the person receiving services, the parent of a minor, or the guardian as appropriate;

2. Suspension of rights of persons receiving services occurs only within procedural safeguards as stipulated in section 8.604.3 and that continued suspension of such rights is reviewed by the interdisciplinary team at a frequency decided by the team, but not less than every six months;

3. Emergency control procedures, safety control procedures and Individual Service and Support Plans with restrictive procedures are used in accordance with the requirements of these rules;

4. The use of psychotropic medications and other medications used for the purpose of modifying a person's behavior by persons receiving comprehensive services and supports are used in accordance with the requirements of section 8.609.6.D.7 and 8, and are monitored by the Human Rights Committee on a regular basis; and,

5. Allegations of mistreatment, abuse, neglect and exploitation are investigated and the investigation report reviewed.

8.608.6 INCIDENT REPORTING

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~~A. Community centered boards,~~and ~~service agencies and regional centers shall have a written policy and procedure for the timely reporting, recording and reviewing of incidents which shall include, but not be limited to:~~

~~1. Injury to a person receiving services;~~

~~2. Lost or missing persons receiving services;~~

~~3. Medical emergencies involving persons receiving services;~~

~~4. Hospitalization of persons receiving services;~~

~~5. Death of person receiving services;~~

~~6. Errors in medication administration;~~

~~7. Incidents or reports of actions by persons receiving services that are unusual and require review;~~

~~8. Allegations of abuse, mistreatment, neglect, or exploitation;~~

~~9. Use of safety control procedures;~~

~~10. Use of emergency control procedures; and,~~

~~11. Stolen personal property belonging to a person receiving services.~~

~~B. Reports of incidents shall include, but not be limited to:~~

~~1. Name of the person reporting;~~

~~2. Name of the person receiving services who was involved in the incident;~~

~~3. Name of persons involved or witnessing the incident;~~

~~4. Type of incident;~~

~~5. Description of the incident;~~

~~6. Date and place of occurrence;~~

~~7. Duration of the incident;~~

~~8. Description of the action taken;~~

~~9. Whether the incident was observed directly or reported to the agency;~~

~~10. Names of persons notified;~~

~~11. Follow-up action taken or where to find documentation of further follow-up; and,~~

~~12. Name of the person responsible for follow-up.~~

~~C. Allegations of abuse, mistreatment neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the agency administrator or designee, and to the community centered board within 24 hours.~~

~~D. Reports of incidents shall be placed in the record of the person.~~

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E. Records of incidents shall be made available to the community centered board, and the Department upon request.

F. Community centered boards,and program approved service agencies and regional centers shall review and analyze information from incident reports to identify trends and problematic practices which may be occurring in specific services and shall take appropriate corrective action to address problematic practices identified.

G. Community centered boards must follow all critical incident reporting requirements outlined at Section 8.519.16.

[SECTION 8.608.7 REMAINS UNCHANGED AND UNAFFECTED BY THIS RULEMAKING]

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8.608.8 ABUSE, MISTREATMENT, NEGLECT, AND EXPLOITATION

A. Pursuant to Section 25.5-10-221, C.R.S., all Community Centered Boards, case management agencies,and service agencies and regional centers shall prohibit abuse, mistreatment, neglect, or exploitation of any person receiving services.

B. Community Centered Boards, case management agencies,and program approved service agencies and regional centers shall have written policies and procedures for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any person receiving services. These policies and procedures must be consistent with state law and:

1. Definitions of abuse, mistreatment, neglect, or exploitation must be consistent with state law and these rules;

2. Provide a mechanism for monitoring to detect instances of abuse, mistreatment, neglect, or exploitation. Monitoring is to include, at a minimum, the review of:

a. Incident reports;

b. Verbal and written reports of unusual or dramatic changes in behavior(s) of persons receiving services; and,

c. Verbal and written reports from persons receiving services, advocates, families, guardians, and friends of persons receiving services.

3. Provide procedures for reporting, reviewing, and investigating all allegations of abuse, mistreatment, neglect, or exploitation;

4. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and contractors who have engaged in abuse, mistreatment, neglect, or exploitation;

5. Ensure that employees and contractors are made aware of applicable state law and agency policies and procedures related to abuse, mistreatment, neglect or exploitation;

6. Require immediate reporting when observed by employees and contractors according to agency policy and procedures and to the agency administrator or his/her designee;

7. Require reporting of allegations within 24 hours to the parent of a minor, guardian, authorized representative, and Community Centered Board or regional center;

8. Ensure prompt action to protect the safety of the person receiving services. Such action may include any action that would protect the person(s) receiving services if determined necessary and appropriate by the service agency or Community Centered Board pending the outcome of the investigation. Actions may include, but are not limited to, removing the person from his/her residential and/or day services setting and removing or replacing staff;

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9. Provide necessary victim supports;

10. Require prompt reporting of the allegation to appropriate authorities in accordance with statutory requirements and pursuant to Section 8.608.8.C;

11. Ensure Human Rights Committee review of all allegations; and,

12. Ensure that no individual is coerced, intimidated, threatened or retaliated against because the individual, in good faith, makes a report of suspected abuse, mistreatment, neglect or exploitation or assists or participates in any manner in an investigation of such allegations in accordance with Section 8.608.8.D.

C. Any and all actual or suspected incidents of abuse, mistreatment, neglect, or exploitation shall be reported immediately to the agency administrator or designee. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, Section 19-3-304, C.R.S., (Colorado Children's Code), Section 18-6.5-108, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Section 26-3.1-102, C.R.S., (Human Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

D. All alleged incidents of abuse, mistreatment, neglect, or exploitation shall be thoroughly investigated in a timely manner using the specified investigation procedures. However, such procedures must not be used in lieu of investigations required by law or which may result from action initiated pursuant to Section C, above.

1. Within 24 hours of becoming aware of the incident, a critical incident report shall be made available to the agency administrator or designee and the Community Centered Board or regional center.

2. The agency shall maintain a written administrative record of all such investigations including:

a. The incident report and preliminary results of the investigation;

b. A summary of the investigative procedures utilized;

c. The full investigative finding(s);

d. The actions taken; and,

e. Human Rights Committee review of the investigative report and the action taken on recommendations made by the committee.

3. The agency shall ensure that appropriate actions are taken when an allegation against an employee or contractor is substantiated, and that the results of the investigation are recorded, with the employee's or contractor's knowledge, in the employee's personnel or contractor's file.

8.609 PROGRAM SERVICES AND SUPPORTS

8.609.1 SUPPORT SERVICES

Support services include supported living services for adults 18 years and older and the children's extensive support program for children through age 17.

A. Supported Living Services for adults are intended to provide the necessary assistance and support to meet the daily living and safety needs of persons who are responsible for their own living arrangements in the community. Services are intended to augment available supports for those individuals who can live independently with limited supports, or who, if they need extensive support, are getting that support from other sources.

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B. Children's extensive support services are intended to provide the services and supports to children most in need because of the severity of the disability and provide for stability of the family setting which would allow the child to continue to remain in the family home.

C. Medicaid funded supported living services for adults and children's extensive support services are provided through the home and community based services program which is described in Section 8.500.

8.609.2 SUPPORT SERVICES GENERAL PROVISIONS

A. Services and supports shall be provided pursuant to the person's Individualized Plan and Individual Service and Support Plans, as appropriate.

Individual Service and Support Plans shall be developed, as needed, to ensure that services and supports are provided consistently and reach the intended results, as determined by the Interdisciplinary Team.

B. Services and supports provided shall be in accordance with the Department's rules.

C. Each support coordinating agency shall be responsible to ensure there is no interruption of services and supports that are critical to a person's health and safety and which if not delivered could result in imminent harm to the person.

D. Individuals, parents of a minor or guardians shall have the opportunity to choose and direct services necessary to meet their identified and prioritized needs and to choose among qualified service providers. Provision of services by family members, as defined in Section 25.5-10-202(16), C.R.S., living in the same household (under the same roof and same physical address) with the program participant shall be on an exception basis only and in accordance with the requirements of the applicable Medicaid waiver.

E. Each support coordinating agency shall establish and implement written procedures for:

1. The assignment of resources as prescribed by the Department; and,

2. Approving expenditures for adaptations and devices as prescribed by the Department.

F. For persons receiving services who are assisted in the administration of medications by a person other than a relative, the following is required:

1. A written record of medications, including time and the amount of medication, taken by the person;

2. Written orders by a licensed physician or dentist for all medications;

3. Documentation of the effects of psychotropic medications and any changes in medication; and,

4. The use of medication reminder boxes pursuant to Section 25-1.5-303(1) C.R.S.

G. The support coordinating agency shall provide for the regular monitoring of the health, safety and welfare of persons and the services and supports provided.

H. The support coordinating agency shall conduct an evaluation of consumer satisfaction no less than every three (3) years. The evaluation shall, at a minimum, include satisfaction with choice of services and providers.

I. The support coordinating agency shall maintain a record for each person receiving services which includes the information required by these rules and as prescribed by the Department.

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Staff, providers and other support personnel shall have ready access to records and information required by them to carry out their responsibilities.

8.609.3 CHILDREN'S EXTENSIVE SUPPORT PROGRAM

A. The child participating in the Children's Extensive Support Program shall live at home with his/her biological, adoptive parent(s) or guardian, or be in an out of home placement and being returned home with the provision of the program.

B. There shall be a record that the child's physician has certified that the medical services and supports identified in the Individualized Plan are sufficient to meet the child's needs in the home setting.

8.609.4 COMPREHENSIVE HABILITATION SERVICES AND SUPPORTS

Medicaid funded Comprehensive Habilitation Services and Supports are provided through the Home and Community Based Services program which is described in the Colorado Department of Health Care Policy and Financing rules and regulations, Medical Assistance staff manual, section 8.500 (10 C.C.R. 2505-10) and the Department's program descriptions. State funded Comprehensive Habilitation Services and Supports are provided pursuant to the Department's program description. Comprehensive Habilitation Services and Supports specifically for individuals with developmental disabilities include:

A. Residential Habilitation Services and Supports

1. Individual Residential Services and Supports

2. Group Residential Services and Supports

B. Day Habilitation Services and Supports

1. Integrated employment services

2. Integrated activities services

3. Prevocational services

4. Other activities services

C. Transportation Acquisition Services

8.609.5 RESIDENTIAL HABILITATION SERVICES AND SUPPORTS DESCRIPTION AND GENERAL PROVISIONS

Residential Habilitation Services and Supports provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training (i.e., instruction, skill acquisition) and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services and supports are designed to meet the unique needs of each person determined by the assessed needs, personal goals, and other input provided by the Interdisciplinary Team, defined at Section 8.519.1, and to provide access to and participation in typical activities and functions of community life.

A. Program Approved Service Agency Policies, Procedures and Service Provisions

1. Each Program Approved Service Agency (PASA) providing residential services must establish and implement written policies and procedures concerning the use, handling and timely disbursement of personal needs funds and include a record of personal possessions, including clothing, of the participant.

2. PASAs must conduct an evaluation of consumer satisfaction with services and supports no less than every two years. The PASA must review and analyze this data and address any

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complaints or problematic practices requiring corrective action. PASAs must make the results of the survey available to interested stakeholders upon request.

3. The PASA must maintain a record for each participant which includes the information required by these rules and as prescribed by the Department.

4. Participants receiving Residential Habilitation Services and Supports must have 24-hour supervision. Supervision may be on-site (direct service provider or caregiver is present) or accessible (direct service provider or caregiver is not on site but available to respond when needed). Staffing arrangements must be adequate to meet the health, safety and welfare of participants and the needs of the individual as determined by the Service Plan. The PASA is responsible for verifying that any direct care provider they employ or contract with has the capacity to serve the individuals in their care, as outlined in the Support Plan.

5. Physical facilities utilized as residential settings must meet all applicable fire, building, licensing and health regulations.

6. Services and supports must be provided pursuant to the person's Service Plan, in accordance with Department guidelines and service descriptions, and the HCBS Settings Final Rule at 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified in relevant part at 42 C.F.R. § 441.301).

7. The PASA is responsible for providing services, supplies and equipment as prescribed by the Department.

8. Caregivers, providers and other support personnel must have ready access to records and all necessary, detailed protocols about the participant required to carry out their responsibilities.

9. PASAs must comply with the Colorado Adult Protection Services (CAPS) requirements, outlined in §26-3.1-111, C.R.S. and 12 CCR 2518-1, Volume 30.960. The PASA must maintain accurate records and make records available to the Department upon request.

   a. Direct service provider means any person providing direct services and supports, including case management services, protective services, physical care, mental health services, or any other service necessary for the at-risk adult's health, safety, or welfare, pursuant to C.R.S. 26-3.1-101 (3.5). Direct service provider includes PASA applicants and owners, as they are ultimately responsible for the members they serve.

   b. During the enrollment process the PASA may be granted provisional approval to render Medicaid services. Final PASA approval is contingent on submission of documentation of a completed CAPS check on the PASA applicant and owner within 90 days from the receipt of the provisional approval.

      i. Failure to submit the required documentation within 90 days of the provisional approval period may result in rescindment of the provisional approval.

      ii. For the purposes of C.R.S. 26-3.1-111 (6)(a)(III), the Department of Health Care Policy and Financing is the oversight agency for PASAs and must be informed of CAPS check results for employers who run them on themselves.

   c. Direct Service and backup providers with any of the following are prohibited from providing IRSS to any participant :

      i. A substantiated allegation of abuse, neglect, exploitation, or harmful act, as defined in Section 26-3.1-101, C.R.S., within the last 10 years, by APS at a

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severity level of "Moderate" or "Severe" as defined in 12 CCR 2518-1 Section 30.100;

ii. Three or more substantiated allegations of abuse, neglect, exploitation, or harmful act, as defined in Section 26-3.1-101, C.R.S., within the last five years, by APS at the minor severity level as defined in 12 CCR 2518 Section 30.100; or

iii. A criminal conviction of abuse, neglect, or exploitation against an at-risk adult with IDD as defined in Section 18-6.5-102, C.R.S.

iv. Only substantiated allegations that have exhausted the appeal period and come to a final disposition, as defined as 12 CCR 2518-1 Section 30.920, shall be included in the above exclusions list.

10. Incident Reporting

a. The PASA must comply with all incident reporting requirements, as outlined in Section 8.608.6.

b. The PASA must notify guardians and/or representatives of Incident Reports (IR).

c. The PASA must have policies and procedures in place for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any participant, pursuant to Section 8.608.8.

d. The PASA must notify the waiver participant and guardians and/or participants' representatives of investigations, including summary information pertaining to the outcome of the investigation, victim supports accessed, and recommendations to prevent recurrence.

11. The PASA is responsible for the monitoring of conditions at the property and must provide oversight and guidance to safeguard the health, safety, and welfare of the participant.

12. The PASA must provide for and document the regular on-site monitoring of Residential Habilitation Services and Supports. PASA's must conduct an on-site visit of each Individual Residential Support Services (IRSS) or Group Residential Support Services (GRSS) setting before a participant moves in, and at a minimum once every quarter, with at least one visit annually that is unscheduled. On-site monitoring of IRSS and GRSS settings must include, but not be limited to:

a. Inspection of all smoke alarms and carbon monoxide detectors;

b. Ensuring all exits are free from blockages to egress;

c. Review of each participant's emergency and disaster assessment; and

d. Medication administration records and physician orders.

B. Rights of Participants

1. A participant must be presumed able to manage his/her own funds and possessions unless otherwise documented in the Service Plan.

2. Participants must have a key or key code to their home, a bedroom door with a lock, lockable bathroom doors, access to all common areas of the home, and a residential agreement that provides protections for evictions.

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3. A participant, guardians, authorized representatives, as appropriate, and the case manager shall be notified at least fifteen (15) days prior to proposed changes in residential placements.

a. If an immediate move is required for the protection of the person, notification must occur as soon as possible before the move or no later than three days after the move.

b. A participant, guardians, and authorized representatives, as appropriate, must be involved in planning subsequent placements and any member of the Interdisciplinary Team may request a meeting to discuss the change in placement.

c. When a participant moves settings or PASA, all residential PASA's involved must be present for the move whenever possible, and will ensure all possessions, medications, money and pertinent records are transferred to the participant within 24 hours.

d. If the participant, guardians, or authorized representative, as appropriate, wants to contest the move they should follow the grievance procedure of the agency.

e. If there is a concern regarding the health, safety, or welfare of the person being jeopardized as a result of the move, any interested party may request an emergency order from the Department pursuant to Section 8.605.4.

4. Participants have a right to annual notification of PASA appeal/grievance policies and procedures.

8.609.6 COMPREHENSIVE HABILITATION SERVICES AND SUPPORTS MEDICAL, THERAPY, AND MEDICATION PROVISIONS

A. Persons receiving comprehensive services and supports shall be assured of medical and dental services necessary to maintain the health of the person and to prevent further disability and shall have dentures, eyeglasses, hearing aids, braces and other aids or therapies as prescribed by an appropriate professional.

B. Each program approved service agency shall have provisions for emergency medical care and procedures to be followed in rendering emergency medical care.

C. Therapy assessments shall be completed as the need for these is identified by the interdisciplinary team and/or physician. Based on these assessments, therapies shall be provided to maintain the health of the person receiving services, to prevent further disability and, whenever possible, to improve the overall functioning of the person receiving services.

1. Therapy programs shall be periodically reviewed by a professional therapist from the relevant specialty area.

2. Persons receiving services who use wheelchairs and other assistive technology services shall receive professional reviews, at a prescribed or recommended frequency, to ascertain the continued applicability and fitness of those devices.

3. Wheelchairs and other assistive technology devices shall be maintained in good repair.

D. The program approved service agency shall provide sufficient supports to persons receiving services in the use of prescription and non-prescription medications to protect the health and safety of persons receiving services. Decisions concerning the type and level of supports provided shall be based on the abilities and needs of the person receiving services as determined by assessment and shall be in compliance with these rules.

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1. Each program approved service agency shall establish and implement written procedures for the appropriate procurement, storage, distribution and disposal of medications.

   a. All drugs shall be stored under proper conditions of temperature, light, and with regard for safety.

   b. Discontinued drugs, outdated drugs, and drug containers with worn, illegible, or missing labels shall be promptly disposed of in a safe manner.

   c. A record shall be maintained of missing, destroyed or contaminated medications.

   d. The use of medication reminder boxes shall be pursuant to section 25-1.5-303(1) C.R.S.

2. No prescription medication shall be administered without a written order by a licensed physician or dentist.

3. The drug regimen of each person receiving services on prescription medication shall be reviewed and evaluated by a licensed physician no less often than annually and more frequently if recommended by the physician or required by law.

4. Refusals to take medications by a person receiving services and drug reactions shall be recorded. On-going refusals to take medications shall be addressed by the person's physician.

5. For persons receiving services who are not independent in the administration of their own medications the following shall be required:

   a. A written record of medications, including time and the amount of medication, taken by the person receiving services; and,

   b. Physician orders for over the counter medications.

6. For persons receiving services who are independent in the administration of medications and who do not require monitoring each time medication is taken, the program approved service agency shall provide sufficient, at minimum quarterly, monitoring or review of medications to determine that medications are taken correctly.

7. Psychotropic medication for persons receiving residential services and supports shall be used only for diagnosed psychiatric disorders and:

   a. When a specific psychiatric evaluation or consultation has resulted in the recommendation for use of medication;

   b. When the person's Individualized Plan specifies the use of psychotropic medication;

   c. After informed consent of the person receiving services, the parent of a minor, or the legal guardian of an adult has been obtained or pursuant to a valid court order;

   d. After completion of a comprehensive review of the person's life situation and an Individual Service and Support Plan. The Individual Service and Support Plan shall explain the specific methodologies, strategies or procedures that will be implemented to assist the person to maintain stability or that will be implemented in a crisis; and,

   e. When reviewed by the Human Rights Committee.

8. Administration of psychotropic medications to a person receiving residential services and supports shall:

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a. Be authorized through a time-limited prescription of no more than ninety (90) days by a fully licensed physician and reviewed at least annually by a psychiatrist;

b. Be in the minimum effective dose possible;

c. Allow for gradual reduction of the dosage and ultimate discontinuation of the drug, unless clinical data establishes the presence of a psychiatric condition requiring that a maintenance level of the drug be administered;

d. Ensure employees and contractors are knowledgeable of potential side effects and adverse reactions to the drugs;

e. Include regular monitoring of the person receiving services for potentially irreversible side effects such as tardive dyskinesia and other abnormal movements and effects, neurotoxicity, and neuroleptic malignant syndrome;

f. Include documentation of the effects of medications and any changes in medication; and,

g. Not be ordered on a PRN or "as needed" basis.

8.609.7 INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) SPECIFICATIONS

A. Individual Residential Services and Supports (IRSS) use a variety of living arrangements to meet the unique needs for support, guidance and habilitation of each participant.

1. IRSS settings include, but are not limited to:

a. a home owned, leased or controlled by the Program Approved Service Agency (PASA);

b. a home of a family member;

c. their own home; or

d. a Host Home.

i. The Host Home is the primary residence of the provider, which means that the Host Home provider occupies the residence seventy-five (75) percent of the time. The Host Home provider may not contract to provide services to more than three (3) individuals, inside or outside of the Host Home, at any given time.

B. Program Approved Service Agency Policies, Procedures and Service Provisions

1. The PASA has the responsibility for the living environment, regardless of the setting type.

2. IRSS may be provided to no more than three participants in a single setting. For each participant in a setting, the PASA must ensure the following criteria are met and documented:

a. The participants involved elect to live in the setting;

b. Each participant must have their own bedroom, unless they elect to share a bedroom with a roommate of their choice, which must be documented in the Service Plan;

c. Back-up providers are identified, available and agreed upon by the participant and PASA. When a back-up provider is not available, the PASA assumes responsibility for identifying a provider;

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d. The PASA and case management agency of each participant in the setting must be involved in the coordination of placement of each participant;

e. Participants are afforded regular opportunities for community inclusion of their choice;

f. Participants are afforded individual choice, including preference to live near family;

g. Distance from other homes (e.g., apartments, houses) of participants is examined so that persons with developmental disabilities are not grouped in a conspicuous manner;

h. For the placement of an individual into a three-person setting, the following factors must be examined to determine reasonableness of the placement:

i. Level of care and needs of each participant in the home;

ii. Availability to support and provide supervision to participants;

iii. Compliance with HCBS Settings Final Rule at 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified in relevant part at 42 C.F.R. § 441.301); and

iv. Each participant's ability to evacuate.

i. When three participants reside in a single setting, the PASA must conduct monthly monitoring of the setting.

3. Participants must live safely in environments common to other citizens with reasonable and appropriate supports provided to protect their health and safety while simultaneously promoting community inclusion. Providers and caregivers must have the appropriate knowledge, skills, and training to meet the individual needs of the participant before providing care and services. The PASA must have policies and procedures in place outlining the required trainings for providers and caregivers. The policy and procedure shall include, but not be limited to, the following:

a. Training specific to the participants' needs shall be completed by all providers and caregivers. Such training shall include, at a minimum, medical protocols and activities of daily living needs.

b. Providers and caregivers shall receive training in resident rights, abuse and neglect prevention, and reporting abuse, neglect, mistreatment and exploitation.

4. Upon enrollment in services, the PASA must assess each participant's ability to care for their safety needs and take appropriate action in case of an emergency. The assessment must be kept up to date and, at a minimum, address the following emergencies and disasters:

a. Fire;

b. Severe weather and other natural disasters;

c. Serious accidents and illness;

d. Assaults; and,

e. Intruders.

5. There must be a written plan for each person addressing how the emergencies specified above will be handled. The plans must be based on an assessment, maintained current and shall, at minimum, address:

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a. Specific responsibilities/actions to be taken by the participant, approved caregivers or other providers of supports and services in case of an emergency;

b. How the participant will evacuate in case of fire by specifying, at minimum, two exit routes from floors used for sleeping and the level of assistance needed; and

c. Telephone access (by the participant or with assistance) to the nearest poison control center, police, fire and medical services.

6. Safety plans and evacuation procedures must be reviewed and practiced at sufficient frequency and varying times of the day, but no less than once a quarter, to ensure all persons with responsibilities for carrying out the plan are knowledgeable about the plan and capable of performing it. All safety plans must be on site at the home and be reviewed by the PASA agency during each on-site monitoring visit.

7. The PASA must provide sufficient oversight and guidance and have established procedures to ensure that the health and medical needs of the participant are addressed. This includes:

a. Each participant must have a primary physician;

b. Each participant must receive a medical evaluation at least annually unless a greater or lesser frequency is specified by his/her primary physician. If the physician specifies an annual evaluation is not needed, a medical evaluation must be conducted no less frequently than every two years;

c. Each participant must be encouraged and assisted in getting a dental evaluation annually;

d. Other medical and dental assessments and services must be completed as the need for these is identified by the physician, dentist, other medical support personnel or the Interdisciplinary Team; and

e. Records must contain documentation of:

i. medical services provided;

ii. results of medical evaluations/ assessments and of follow-up services required, if any;

iii. acute illness and chronic medical problems; and,

iv. weight taken annually or more frequently, as needed.

8. The PASA must have a written contract with each direct service provider that is not directly employed by the PASA and is providing IRSS under the PASA's authority, regardless of the setting type. This includes but is not limited to Host Home providers and family caregivers not directly employed by the PASA.

a. A current list of the above-mentioned contracted IRSS providers and their accompanying contracts must be on file with the program approved service agency and a copy must be provided to the Department or its agent upon request.

b. Each contract must be in writing and contain the following information:

i. Name of contracted IRSS provider;

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ii. Responsibilities of each party to the contract, including, but not limited to, responsibility for the safety and accessibility of the physical environment of the home;

iii. An agreement outlining the living arrangements, monitoring of the Host Home, Host Home provider's duties, and any limitations on the Host Home providers duties;

iv. Expectations that participants be provided opportunities for informed choice over a variety of daily choices similar to those exercised by non-participants;

v. Process for correcting non-compliance;

vi. Process for termination of the contract;

vii. Process for modification or revision of the contract;

viii. Process for relocation of the participant if they are in immediate jeopardy of actual or potential for serious injury or harm;

ix. Process for coordinating the care of the participant;

x. Payment rate and method;

xi. Beginning and ending dates; and

xii. A clause that states the contracted IRSS provider shall not sub-contract with any entity to perform in whole the work or services required under the IRSS benefit.

c. PASAs who utilizes the services of subcontractors are responsible for the following, which includes but is not limited to:

i. Vetting, training, monitoring, and taking corrective action with employees and subcontractors.

ii. Nothing in these regulations shall create any contractual relationship between any subcontractor of the PASA and the Department.

d. If a contract is terminated with a contracted IRSS provider due to health, safety or welfare concerns, the PASA must report to the following parties:

i. Within 4 days to the Department or its agent regarding the cited reason for termination of a contracted IRSS provider.

ii. Within 4 days to the guardian or authorized representative and case manager of the participant from the terminated contracted IRSS provider.

9. The PASA must require each contracted direct service provider providing IRSS to document each approved caregiver(s) and report to the agency the names of all persons that reside in the home. Participants and/or guardians have a right to request and receive from the rendering PASA a list of all direct service and backup providers that are approved to provide them services. No backup provider may be hired without PASA approval. The agency must ensure criminal background checks are completed for any non-participant over the age of 18 who lives in the home.

10. The IRSS direct service provider is prohibited from conduct that would pose a risk to the health, safety and welfare of the member including the members mental health.

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11. Each PASA must provide quarterly housing and participant updates to the Department or its agent through a specified data collection platform. Failure to provide these quarterly updates may result in payment suspension.

12. The PASA must ensure nutritionally balanced meals are available to participants. Based on an assessment of the person's capabilities, preferences and nutritional needs, the PASA may provide guidance and support to monitor nutritional adequacy.

a. Therapeutic diets must be prescribed by a licensed physician or dietician.

b. Participants must have access to food at all times, choose when and what to eat, the opportunity to provide input into menu planning, comfortable seating for meals where they can choose their own seat, and shall have access to food preparation areas as documented in the Service Plan.

C. Living Environment

1. Homes of participants must, at minimum, meet standards set forth in the Colorado Division of Housing (DOH) IRSS Inspection Protocol. The following setting types must pass the DOH IRSS Inspection Protocol every two years:

a. All Host Homes; and

b. All IRSS settings that are owned or leased by a PASA.

Settings must request an inspection prior to placement of a participant and must pass an inspection within 90 days of becoming an approved setting and providing services. Existing settings have until January 1, 2022 to pass an inspection.

2. The PASA must have a protocol in place for the emergency placement of the participant if a home is deemed not safe by the Division of Housing (DOH).

3. The home (exterior and interior) and grounds must:

a. Be maintained in good repair;

b. Protect the health, comfort and safety of the participant; and

c. Be free of offensive odors, accumulation of dirt, rubbish and dust.

4. There must be two means of exit from floors with rooms used for sleeping. Exits must remain clear and unobstructed.

5. The PASA must ensure entry to the home and an emergency exit is accessible to participants, including participants utilizing a wheelchair or other mobility device.

6. The PASA must ensure that participants who utilize a wheelchair or other mobility device have access to all common areas of the home

7. Bedrooms must meet minimum space requirements (single 80 square feet, double 120 square feet). (Not applicable for studio apartments.)

8. Adequate and comfortable furnishings and supplies must be provided and maintained in good condition.

9. Participants have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment.

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10. A fire extinguisher must be available in each home. Presence of an operational fire extinguisher shall be confirmed by the PASA during each on-site monitoring visit.

a. PASA's must follow manufacturer specifications and expiration dates for all fire extinguishers.

11. Smoke alarms and carbon monoxide detectors must be installed in the proper locations in each home to meet Housing and Urban Development (HUD) requirements and/or local ordinances. Smoke and carbon monoxide detectors shall be tested during each on-site monitoring visit by the PASA.

8.609.8 GROUP RESIDENTIAL SERVICES AND SUPPORTS SPECIFICATIONS

A. Group Residential Services and Supports (GRSS) encompass group living environments of at least four and no more than eight persons receiving services.

B. A community residential home for individuals with developmental disabilities shall not be located within 750 feet of another such group home or within 750 feet of facility-based day programs or other program services operated for people with developmental disabilities unless previously approved by the Department.

C. Group Residential Services and Supports shall comply with the Colorado Department of Public Health and Environment Chapter VIII, Part 5 Rules and Regulations, in addition to these rules, and be licensed by the Colorado Department of Public Health and Environment.

D. No residential services and supports for individuals with developmental disabilities shall be recommended for licensure by the Colorado Department of Public Health and Environment, if required, unless approved by the Department.

E. The program approved service agency shall ensure a sufficient number of staff to meet licensing requirements and the needs of persons receiving services as determined by the Individualized Plan.

8.609.9 DAY HABILITATION SERVICES AND SUPPORTS

A. Day Habilitation Services and Supports provide training, support and supervision activities which maximize functional abilities and skills necessary to enable adults to access the community and/or provide the basis for building skills which will assist individuals to access the community.

1. Day Habilitation Services and Supports are to be provided outside of the person's living environment, unless otherwise indicated by the person's needs, through meaningful employment, activities and community participation. If services cannot be provided outside of the living environment due to a person's medical or safety needs, this shall be documented.

2. Integrated employment should be considered as the primary option for all persons receiving Day Habilitation Services and Supports.

3. Day Habilitation Services and Supports include:

a. Integrated employment services (supported employment) which provide individuals with considerable ongoing job related services and supports to obtain and maintain paid work in a regular community work setting.

b. Integrated activities services which utilize the community as a learning environment to provide individuals access to, and participation in, typical activities and functions of community life. These services provide a variety of opportunities to facilitate

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relationships and natural supports in the community through activities such as volunteer work, community education or training and retirement activities.

c. Prevocational services which are provided in accordance with Section 8.500.5.B.2.c.

d. Other services engage individuals in a variety of functional activities which are primarily habilitative in nature with an emphasis on skill development and focus on generalizing those skills..

B. The physical facilities where day habilitation services are provided shall meet requirements for physical facilities pursuant to section 8.610.

C. Each program approved service agency shall have written plans to address emergencies regardless of service location or type of program.

8.610 FACILITY BASED ADULT DAY HABILITATION SERVICES AND SUPPORTS

The physical facilities where Adult Day Habilitation Services and Supports are provided to individuals receiving comprehensive or supported living services shall meet all applicable fire, building, licensing and health regulations.

A. The physical facilities over which the service agency exercises control shall also meet the following requirements:

1. The physical facilities shall be inspected by the local fire authority prior to occupancy and at least once every three years thereafter. The local fire authority shall be informed of the purpose of the facility and potential mobility or ambulation needs of individuals served. If the purpose of the facility changes and impacts the individuals to be served in that facility, then the service agency shall be responsible for informing the local fire authority to determine if another inspection is required.

2. The service agency shall conduct fire drills at least quarterly at each physical facility.

3. All physical facilities shall have smoke detectors and fire extinguishers.

4. All physical facilities shall have first-aid supplies available.

5. All program approved service agencies shall comply with the Americans with Disabilities Act (ADA) with regard to physical facilities.

B. If the service agency provides services in the community to persons who may visit the offices of the service agency (or another service operated facility), but the persons receive services at such location(s) for less than one hour per visit, requirements of section 8.610.A.1-4 do not apply. The service agency shall, however, ensure that the facility complies with the ADA and contains no hazards which could jeopardize the health or safety of persons visiting the site.

C. For physical facilities used as community integrated sites over which the service agency exercises little or no control, the program approved service agency shall:

1. Conduct an on-site visit to ensure that there is no recognizable safety or health hazards which could jeopardize the health or safety of individuals;

2. Address any safety or health hazards which could jeopardize the health or safety of individuals with the owner/operator of the physical facility.

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D. Each program approved service agency shall have written plans to address emergencies which occur during service hours regardless of service location or type of program.

8.611 TRANSPORTATION

A. Definitions

1. Non-Medical Transportation (NMT) services means transportation which enables eligible participants to gain physical access to non-medical community services and supports, as required by the care plan to prevent institutionalization.

2. Non-Medical Transportation Provider (provider) means a provider agency that has met all standards and requirements as specified in Section 8.611.

3. Transportation acquisition services refers to the purchase or provision of transportation for participants receiving day program services under comprehensive services which enables them to gain access to programs and other community services and resources required by their Individualized Plan/Plan of Care. Funding for transportation activities incidental to the Residential Program are included in the Residential rate.

B. Exclusions

1. Non-Medical Transportation services shall not be used to substitute for medical transportation, as defined in Section 8.014.

2. Non-Medical Transportation services shall only be used after the case manager has determined that free or no-cost transportation is not available to the participant. Prior to the use of funds for transportation acquisition services, the Community Centered Board, case management agency or program approved service agency shall investigate the feasibility of the use of public transportation options. If public transportation options are found to be inadequate or inappropriate, this shall be documented.

C. Provider Standards for Non-Medical Transportation Services

1. Providers shall conform to all general standards and procedures set forth in Department regulations at Section 8.611.

2. Providers must maintain liability insurance with the following automobile liability limits:

a. Bodily injury (BI) $300/$600K per person/per accident; and

b. Property damage $50,000.

c. Drivers that utilize their personal vehicle on behalf of a provider agency to provide NMT must maintain insurance that meets the following minimum automobile insurance requirements in addition to the insurance maintained by the provider agency :

i. Bodily injury (BI) $25/$50K per person/per accident; and

ii. Property damage $15,000.

3. Providers shall ensure that each driver rendering NMT meets the following requirements:

a. Drivers must be 18 years of age or older to render services;

b. Have at least one year of driving experience;

c. Possess a valid Colorado driver's license;

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d. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history; and

e. Complete a Colorado or National-based criminal history record check.

4. Drivers shall be disqualified from driving for any of the following:

a. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;

b. A conviction in the State of Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;

c. A conviction in the State of Colorado, within the seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);

d. A conviction in the State of Colorado, within the four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15 of Title 18, C.R.S.;

e. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D), when conviction for that offense occurs within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of 4 C.C.R. 723-6, § 6114;

f. A conviction in the State of Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;

g. A conviction in Colorado within the two (2) years preceding the date the criminal history record check is completed of driving under the influence, as defined in § 42-4-1301(1)(f), C.R.S.; driving with excessive alcoholic content, as described in §42-4-1301(1)(g), C.R.S;

h. A conviction within the two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B) in any other state or in the United States; and

For purposes of 4 C.C.R. 723-6 § 6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sentence.

5. Vehicles used during the provision of NMT must be safe and in good working order. To ensure the safety and proper functioning of the vehicles, vehicles must pass a vehicle safety inspection prior to it being used to render services.

a. Safety inspections shall include the inspection of items as outlined in Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; §6104.

b. Vehicles must be inspected on the following schedule:

i. Vehicles manufactured within the last five (5 years:): no inspection.

ii. Vehicles manufactured within the last six (6) to ten (10) years: every 24 months.

iii. Vehicles manufactured eleven (11) years or later: annually.

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iv. Vehicles for wheelchair transportation: annually, regardless of the manufacture date of vehicle.

c. The vehicle inspector must be trained to conduct the inspection and be employed by an automotive repair company authorized to do business in Colorado.

6. Transportation providers who maintain a certificate or permit through the Public Utilities Commission (PUC) are not required to meet the above requirements. PUC certificate and permit holders shall submit a copy of the certification to the Department for verification of provider credentials.

[SECTION 8.612 REMAINS UNCHANGED BY THIS RULEMAKING]

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8.613 FAMILY SUPPORT SERVICES PROGRAM (FSSP)

A. ADMINISTRATION

1. The Community Centered Board (CCB) shall administer the Family Support Services Program (FSSP), subject to available appropriations and according to the rules, regulations, policies and guidelines of the Department, local Family Support Council (FSC) and CCB.

2. The CCB shall ensure that the FSSP is implemented within its designated service area.

3. The CCB shall designate one (1) person as the contact for the overall implementation and coordination of the FSSP.

4. Referrals to the FSSP shall be made through the CCB pursuant to Section 8.607.

5. Nothing in these rules and regulations shall be construed as to prohibit or limit services and supports available to an individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay and their families which are authorized by other state or federal laws.

6. The CCB, in cooperation with the local FSC, shall ensure that the FSSP is publicized within the designated service area.

7. The CCB shall develop written policies and procedures for the implementation and ongoing operation of the FSSP, which must be kept on file and made available to the Department or the public, upon request.

B. FAMILY SUPPORT COUNCIL (FSC)

1. The CCB shall assist its designated service area to establish and maintain an FSC pursuant to Section 25.5-10-304, C.R.S.

2. The CCB shall establish an FSC roster that includes the names of members, type of membership and identifies the chairperson. The roster shall be available to the Department or the public, upon request.

3. Composition of the FSC:

a. The majority of the members and the chairperson of each FSC shall be family members of an individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay.

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b. New members of the FSC shall be recruited from the service area. New members shall be approved by the current FSC and the board of directors of the CCB.

c. The members of the FSC shall receive written notice of their appointment.

d. The CCB shall ensure an orientation and necessary training regarding the duties and responsibilities of the FSC is available for all council members. The training and orientation shall be documented with a record of the date of the training, who provided the training, training topic, and names of attendees.

e. The size of the FSC shall be sufficient to meet the intent and functions of the council, but no fewer than five (5) persons, unless approved by the Department.

f. Each FSC shall establish the criteria for tenure of members, selection of new members, the structure of the council and, in conjunction with the CCB, a process for addressing disputes or disagreements between the FSC and the CCB. Such processes shall be documented in writing. Processes may include a request for mediation assistance from the Department.

4. The FSC duties include providing guidance and assistance to the CCB on the following:

a. Overall implementation of the FSSP;

b. Development of the written annual FSSP report for the designated service area, as defined at Section 8.613.M;

c. Development of written procedures describing how families are prioritized for FSSP funding;

d. Development of written policy defining how an emergency fund is established, funded and implemented. The policy must include a definition of a short-term crisis or emergency and the maximum amount of funds a family may receive per event and/or year;

e. Provide recommendations on defining the “other” service category within the parameters as defined in this part;

f. Monitor the implementation of the overall services provided in the designated service area; and

g. Provide recommendations on how to assist families who are transitioning out of the FSSP.

C. ELIGIBILITY

1. Any individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay, as determined pursuant to Section 25.5-10-211, C.R.S., living with their family is eligible for the FSSP. Living with a family means that the individual's place of residence is with that family.

a. Living with family may include periods of time from one (1) day to up to six (6) months during which time the individual is not in his or her primary residence because of transition into or out of the home.

b. The CCB, in cooperation with the local FSC, shall determine what constitutes a transition.

2. The family and eligible individual shall reside in the State of Colorado.

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3. All eligible individuals 18 and older must provide proof of lawful presence in the United States to receive FSSP funding.

a. Effective July 1, 2022, eligible individuals 18 and older are not required to provide proof of lawful presence in the U.S. to receive FSSP funding.

4. Eligibility for the FSSP does not guarantee the availability of services or supports under this program.

D. WAITING LIST

1. The CCB shall maintain an accurate and up-to-date waiting list of eligible individuals for whom Department funding is unavailable in the current fiscal year.

2. In cooperation with the local FSC, the CCB shall develop written procedures for determining how and which individuals on the waiting list will be enrolled into the FSSP.

3. Individuals receiving ongoing FSSP funding shall not be listed on the waiting list for the program.

4. Individuals determined to be prioritized for FSSP funding shall be served prior to individuals determined at a lower level of prioritization.

5. The CCB must inform eligible families of the program and waiting list procedures and offer assessment and enrollment onto either the waiting list or the program, based on the assessment and available appropriations.

6. Any individual on the waiting list for FSSP may receive emergency funding through the CCB through the FSSP, if the needs meet the parameters set by the FSC and the CCB.

7. Waiting lists shall not exist for any CCB that does not expend all FSSP direct service funds.

E. PRIORITIZATION FOR FAMILY SUPPORT SERVICES PROGRAM (FSSP) FUNDING

1. CCBs must ensure that families with the highest assessed needs shall be prioritized for FSSP state funding.

2. CCBs, in conjunction with the FSC, will develop written procedures that describe how families shall be prioritized and notified of the prioritization process.

3. The assessment process shall be applied equally and consistently to all families who are assessed.

4. CCBs must distribute the prioritization process to families in their designated service area at the time the family requests FSSP funding, when the individual is placed on the waiting list, or upon request.

5. The CCB must notify families in writing of the results of the assessment.

6. All families, both on the waiting list and receiving FSSP services, shall be assessed for level of need on an annual basis or earlier if the family's circumstances change.

7. The assessment must contain the following components:

a. The qualifying individual's disability and overall care need, which includes:

i. The type of disability or condition and the need and complexity of medical or personal care for the individual;

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ii. The need for, frequency of, and amount of direct assistance required to care for the individual; and

iii. The types of services needed that are above and beyond what is typically needed for any individual.

b. The qualifying individual's behavioral concerns including how behaviors disrupt or impact the family's daily life, the level of supervision required to keep the individual and others safe, and the services and frequency required to help with the behaviors.

c. The family composition, which considers obligations and limitations of the parent(s), the number of siblings, disabilities of other family members living in the home, and the level of stability of the family, such as pending divorce or age and disability of parents.

d. The family's access to support networks, which includes the level of isolation or lack of support networks for the family, such as not having extended family nearby, living in rural areas or availability of providers.

e. The family's access to resources such as family income, insurance coverage, HCBS waivers, and/or other private or public benefits.

F. DIRECT SERVICES

1. Services and supports available under the FSSP may be purchased from a variety of providers who are able to meet the individual needs of the family.

2. All services must be needed as a result of the individual's Intellectual and Developmental Disability (IDD) or Developmental Delay and shall not be approved if the need is a typical age-related need. Correlation between the need and the disability must be documented in the Family Support Plan (FSP).

3. All services must be provided in the most cost-effective manner, meaning the least expensive manner to meet the need.

4. All services shall be authorized pursuant to the FSP.

5. Services provided to the family through the FSSP shall not supplant third party funding sources available to the family including, but not limited to, public funding, insurance, or trust funds.

6. CCBs shall not charge a separate fee for assisting individuals to access services identified on the FSP.

7. FSSP funds shall not be used for any donation; religious, political, or otherwise or activities prohibited by law.

8. Direct Services

a. Assistive technology is equipment or upgrades to equipment, which are necessary for the individual with an IDD or Developmental Delay to communicate through expressive and receptive communication, move through or manipulate his or her environment, control his or her environment, or remain safe in the family home.

b. Environmental engineering is home or vehicle modification needed due to the individual's disability and is not a regular maintenance or modification needed by all owners. Modifications to the home or vehicle must be necessary due to the individual's IDD or Developmental Delay; or needed due to health and safety; or to allow the individual to attain more independence; and completed in a cost-effective

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manner. Cost-effective manner means the least expensive manner to meet the identified need. Home modifications are to be limited to the common areas of the home the individual with an IDD frequents, the individual's bedroom, and one bathroom. Other bedrooms and bathrooms shall not be modified. All devices and adaptations must be provided in accordance with applicable state or local building codes and/or applicable standards of manufacturing, design, and installation. Only homes or vehicles occupied and owned by the family where the eligible individual resides may be modified. Minor modifications may be made to rental units with the permission of the landlord. Rental modifications must be made in a way that the modification can be moved with the eligible individual during a change in residence.

c. Medical and dental items prescribed by a licensed medical professional qualified to prescribe such items and are needed to maintain or attain physical health. Medical, dental, and vision services, exams and procedures are available when not covered by another source.

i. Over the counter medications and vitamins are excluded, except as indicated at Section 8.800.4.D, when prescribed by a licensed medical professional qualified to write such prescriptions.

d. Other: Services in this category must be identified in the FSP, are specific to the family, and are limited to:

i. A consultant and/or advocate to assist a family with accessing services outside of the CCB.

ii. Recreational needs of the individual with an IDD or Developmental Delay when the need of recreation is above and beyond the typical need due to the disability or delay. The cost of family recreation passes shall be limited to $650 or one family pass, whichever is less, per fiscal year and shall be limited to use only at community recreation centers. The following items are specifically excluded under the FSSP and shall not be eligible for coverage:

1) Entrance fees for zoos;

2) Museums;

3) Butterfly pavilion;

4) Movie, theater, concerts;

5) Professional and minor league sporting events;

6) Outdoor play structures;

7) Batteries for recreational items; and,

8) Memberships to non-community gyms.

iii. Specialized services as identified by the FSC and CCB, included in their written policy and are available to any family receiving ongoing Family Support Services Program assistance in the service area.

e. Parent and sibling support, which may include special resource materials or publications, cost of care for siblings, or behavioral services or counseling.

f. Professional services are services which require licensure or certification to treat a human condition other than medical, dental or vision, and is provided to the individual with an IDD or Developmental Delay. Professional services must be

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provided by qualified, certified and/or licensed personnel in accordance with the standards and practices of the industry. Professional services may include related support items or activities which are recommended as part of the therapy with supporting documentation from the treating professional. Insurance expenses directly incurred by the individual with an IDD or Developmental Delay are included.

g. Program expenses are services related to serving multiple families and are funded through the direct service line.

i. This service is not identified in the individual's FSP. This service is provided by the CCB for the benefit of multiple families.

ii. Program expense is the maintenance, operation, or enhancement of a resource library that consists of an inventory of goods and equipment used to meet the needs of individuals with an IDD or Developmental Delay on a temporary basis.

iii. Program expense is the cost associated with participation with other community agencies in the development, maintenance, and operation of projects, supports or services that benefit individuals with an IDD or Developmental Delay.

iv. Program expense is the development or coordination of a training event for families.

v. Program expense is the cost of an event sponsored by the CCB for all eligible individuals and their families to meet other families to provide socialization and an opportunity to build a network of support.

vi. Program expense is the development and coordination of group respite.

vii. The FSC in conjunction with the CCB shall determine the maximum amount of direct services to be used for program expenses.

h. Respite is the temporary care of an individual with an IDD that provides relief to the family.

i. Transportation is the direct cost to the family that is higher than costs typically incurred by other families because of specialty medical appointments or therapies. Specialty medical appointments or therapies are defined as appointments needed due to the individual's IDD or Developmental Delay. The direct cost is the cost of transportation, lodging, food expense, and long-distance telephone calls to arrange for or coordinate medical services which are not covered by other sources.

G. CASE MANAGEMENT

Case management is the coordination of services provided for individuals with an IDD or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education, and other services to ensure non-duplication of services, and monitor the effective and efficient provision of services across multiple funding sources.

1. At minimum, the case manager is responsible for:

a. Determining initial and ongoing eligibility for the FSSP;

b. Development, application assistance, and annual re-evaluation of the Family Support Plan (FSP); and

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c. Ensuring service delivery in accordance with the FSP.

2. Family Support Plan Requirements

a. Families enrolled into the FSSP shall have an individualized FSP which meets the requirements of an Individualized Plan, as defined in Sections 25.5-10-202 and 25.5-10-211, C.R.S., and includes the following information:

i. The name of the eligible individual;

ii. The names of family members living in the household;

iii.. The date the FSP was developed or revised;

iv. The prioritized needs requiring support as identified by the family;

v. The specific type of service or support, how it relates to the family need and the individual's disability or developmental delay, and period which is being committed to in the FSP, including, when applicable, the maximum amount of funds which can be spent for each service or support without amending the FSP;

vi. Documentation regarding cost-effectiveness of a service or support, which can include quotes, bids, or product comparisons but must include the reason for selecting a less cost-effective service or support, when applicable.

vii. A description of the desired results, including who is responsible for completion;

viii. The projected timelines for obtaining the service or support and, as appropriate, the frequency;

ix. A statement of agreement with the plan;

x. Signatures, which may include digital signatures of a family representative and an authorized CCB representative;

xi. The level of need;

xii. The length of time the funds are available; and

xiii. A description of how payment for the services or supports will be made.

b. The FSP shall integrate with other Service Plans affecting the family and avoid, where possible, any unnecessary duplication of services and supports.

c. The FSP shall be reviewed at least annually or on a more frequent basis if the plan is no longer reflective of the family's needs.

i. Any changes to the provision of services and supports identified in the FSP are subject to available funds within the designated service area.

ii. Any decision to modify, reduce or deny services or supports set forth in the FSP, without the family's agreement, are subject to the requirements in Section 8.605.

H. MANAGEMENT AND GENERAL ACTIVITIES

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Management and general activities are the financial and corporate administration of the CCB specific to FSSP requirements by the Department.

I. EMERGENCY FUND

1. Each CCB shall establish an emergency fund that may be accessed by any individual eligible for the FSSP when needed due to an unexpected event that has a significant impact on the individual or family's health or safety and impacts the family's daily activities.

2. Any individual with an IDD or Developmental Delay determined by the CCB and living with family shall be eligible to receive emergency funds regardless of the enrollment status of the family.

3. The CCB in conjunction with the Family Support Council shall develop written policies and procedures regarding the Emergency Fund. At a minimum the policies and procedures must:

a. Define the purpose of the emergency fund;

b. Define an unexpected event and significant impact;

c. Describe the process for accessing emergency funds;

d. Describe how funding determination is made;

e. Give a timeline of the determination of the request;

f. Define the maximum funding amount per family or per event; and

g. Describe how families will be notified of the decision in writing.

J. BILLING AND PAYMENT PROCEDURES

1. The CCB shall develop and implement policies, procedures, and practices for maintaining documentation for the FSSP and reporting information in the format and timeframe established by the Department.

2. Families shall maintain and provide either receipts or invoices to the CCB documenting how funds provided to the family through the FSSP were expended. The CCB shall maintain supporting documentation capable of substantiating all expenditures and reimbursements made to providers and/or families, which shall be made available to the Department upon request.

a. When the CCB purchases services or items directly for families, the CCB shall maintain receipts or invoices from the service provider and documentation demonstrating that the provider was paid by the CCB. Receipts or invoices must contain, at a minimum, memberclient and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount due or paid.

b. When the CCB reimburses families for services or items, the CCB shall ensure the family provides the CCB with receipts or invoices prior to reimbursement. The CCB shall maintain receipts or invoices from the families, and documentation demonstrating that the family was reimbursed by the CCB. The CCB must ensure all receipts or invoices provided by the families contain, at a minimum, memberclient and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

c. When the CCB provides funding to the families for the purchase of services or items in advance, the CCB shall notify the families that they are required to submit invoices

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or receipts to the CCB of all purchases made prior to the close of the State Fiscal Year. The CCB must ensure that all receipts or invoices are collected and maintained from the family, as well as documentation demonstrating that the family received funding from the CCB. The CCB must ensure all receipts or invoices provided by the families contain, at a minimum, memberclient and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

3. The CCB shall submit to the Department, on a form and frequency prescribed by the Department, information which outlines individual family use of the FSSP.

4. The CCB shall report only FSSP expenditure data in the format and timeframe as designated by the Department.

K. PROGRAM EVALUATION

1. The CCB, in cooperation with the local Family Support Council, shall be responsible for evaluating the effectiveness of the FSSP within its designated service area on an annual basis.

2. The evaluation may be based upon a family satisfaction survey and shall address the following areas:

a. Effectiveness of outreach/public awareness including:

i. The demographics of participants in comparison to demographics of the service area; and

ii. How well the program integrates with other community resources.

b. Satisfaction and program responsiveness to include:

i. Ease of access to the program;

ii. Timeliness of services;

iii. Effectiveness of services;

iv. Availability of services;

v. Responsiveness to family concerns;

vi. Overall family satisfaction with services; and

vii. Recommendations.

c. Effective coordination and utilization of funds to include:

i. Other local services and supports utilized in conjunction with the FSSP; and

ii. Efficiency of required documentation for receipt of the FSSP.

3. The CCB, and participating families as requested, shall cooperate with the Department regarding statewide evaluation and quality assurance activities, which includes, but is not limited to providing the following information:

a. The maximum amount any one family may receive through the FSSP during the fiscal year; and

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b. The total number of families to be served during the year.

L. PERFORMANCE AND QUALITY REVIEW

1. The Department shall conduct a Performance and Quality Review of the FSSP to ensure that it complies with the requirements set forth in these rules.

2. A CCB found to be out of compliance with these rules through the results of the Performance and Quality Review, shall be required to develop a corrective action plan, upon written notification from the Department. A corrective action plan must be submitted to the Department within ten (10) business days of the receipt of the written request from the Department. A corrective action plan shall include, but not limited to:

a. A detailed description of the action to be taken, including any supporting documentation;

b. A detailed time frame specifying the actions to be taken;

c. Employee(s) responsible for implementing the actions; and

d. The implementation timeframes and a date for completion.

3. The CCB shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The agency shall explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the agency's compliance.

a. Upon receipt of the corrective action plan, the Department will accept, modify or reject the proposed corrective action plan. Modifications and rejections shall be accompanied by a written explanation.

b. In the event that the corrective action plan is rejected, the agency shall re-write the corrective action plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

c. The agency shall implement the corrective action plan upon acceptance by the Department.

d. If corrections are not made within the requested timeline and quality specified by the Department, funds may be withheld or suspended.

M. FAMILY SUPPORT SERVICES PROGRAM (FSSP) ANNUAL REPORT

1. Each CCB shall submit an annual FSSP report to the Department by October 1 of each year. The report will contain two sections.

a. The first section must describe how the CCB plans to spend the FSSP funds in the current fiscal year and will include:

i. Description of the outreach/public awareness efforts for the coming year;

ii. Description of anticipated special projects or activities under the Program Expense service category; and

iii. Goals with measurable outcomes for any changes to the FSSP.

b. The second section of the annual report will describe how the FSSP funds were spent in the previous year and must contain:

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i. The program evaluation outcomes for the previous year as described in this section;

ii. The total amount of funds expended by service category;

iii. The total number of families served and the total number of families placed on the waiting list;

iv. Detailed information for the Program Expense service category to include:

1) The total number of families that utilized services under the Program Expense category;

2) The specific services provided; resource library, special projects, training events, social events, or group respite;

3) How these services enhanced the lives of families in the community and the total number of families who participated in each project; and

4) The report shall include the total number of staff, total of staff cost, and other costs associated with the Program Expense service category.

iv. A description of how the annual FSSP report was distributed to eligible families; and

v. The signature of Family Support Council (FSC) members, the FSSP Coordinator, and the CCB Executive Director.

8.614 GASTROSTOMY SERVICES

Gastrostomy services shall not be provided by any person who is not otherwise authorized by law to administer gastrostomy services except under the supervision of a licensed nurse or physician pursuant to the requirements of these rules.

A. An individual who is not authorized by law to administer gastrostomy services may administer gastrostomy services to an individual requiring gastrostomy services only if a licensed nurse or physician first:

1. Develops a written individualized protocol for the individual receiving gastrostomy services which is based on the individual's physician orders, meets the requirements of section 8.614.E, and is updated each time that the physician's orders change for that individual's gastrostomy services;

2. Oversees training given to the unlicensed person and documents such training, as provided in section 8.614.G, and directly observes the unlicensed person performing the gastrostomy services until such time as the unlicensed person reaches proficiency, which is defined as such person performing all aspects of the individualized protocol referred to above, at least three consecutive observations without error, and,

3. Performs gastrostomy services for each individual receiving such services at least once prior to the time that the unlicensed person provides any such services for that individual.

B. For staff who are performing gastrostomy services for several individuals with similar protocols, the licensed nurse or physician overseeing their training may document their proficiency with less than three (3) observations for each individual receiving services. The alternative method for establishing proficiency of each staff shall be documented.

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C. A licensed nurse or physician shall monitor each unlicensed person who is performing gastrostomy services for an individual requiring such services pursuant to section 8.614.A, to ensure that such unlicensed person is properly implementing the orders of the physician and the individualized protocol referred to in section 8.614.A, on a quarterly basis during the first year and semi-annually thereafter, unless more frequent monitoring is required by the individualized protocol. Such monitoring shall be documented in the record of the individual receiving gastrostomy services.

D. When changes are made in the physician's order for gastrostomy services and/or in the individual's protocol, the licensed nurse or physician overseeing the training shall determine the extent of training required to ensure that the unlicensed person(s) authorized to provide such services pursuant to section 8.614.A, continues to be proficient in performing all aspects of gastrostomy services.

E. An individualized protocol shall be maintained in the record of the individual receiving gastrostomy services for whom it is prepared and shall include at least the following:

1. The proper procedures for preparing, storing and administering gastrostomy services;

2. The proper care and maintenance of the gastrostomy site, needed materials and equipment;

3. The identification of possible problems associated with gastrostomy services; and,

4. A list of health professionals to contact in case of problems, including the physician of the individual receiving gastrostomy services and the licensed nurse(s) and/or physician(s) who are responsible for monitoring the unlicensed person(s) performing gastrostomy services pursuant to section 8.614.C.

F. A licensed physician shall review and approve the individualized protocol for each individual receiving gastrostomy services through a nasogastric tube.

G. The licensed nurse or physician who oversees the training given to an unlicensed person to perform gastrostomy services for the individual pursuant to section 8.614.A shall document in the record of such individual the following:

1. The date or dates on which the training occurred;

2. The fact that, in the opinion of such licensed nurse or physician, the unlicensed individual has reached proficiency in performing all aspects of the individualized protocol referred to in section 8.614.A.1; and,

3. The legible signature and title of such licensed nurse or physician.

H. Notwithstanding anything contained in these regulations to the contrary, any person administering medication(s) through gastrostomy tubes shall be subject to the requirements of section 25-1.5-303, C.R.S.

I. The program approved service agency shall assure that there is documentation in the record of each individual receiving gastrostomy services for each gastrostomy service provided to him or her, the following, at a minimum:

1. A written record of each nutrient or fluid administered;

2. The beginning and ending time of the nutrient or fluid intake;

3. The amount of nutrient or fluid intake;

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~~4. The condition of the skin surrounding the gastrostomy site;~~

~~5. Any problem(s) encountered and action(s) taken; and,~~

~~6. The date and signature of the person performing the procedure.~~

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~~8.615 TELEHEALTH DELIVERY OF HOME AND COMMUNITY-BASED SERVICES~~

~~8.615.1 DEFINITIONS~~

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~~A. Assessment shall be as defined at Section 8.390.1.DEFINITIONS.~~

~~B. Case Management means as defined in Section 8.390.1 DEFINITIONS.~~

~~C. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.~~

~~D. Community Centered Board (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 25.5-10-209, C.R.S., provides case management services to Members with developmental disabilities, is authorized to determine eligibility of such Members within a specified geographical area, serves as the single point of entry for Members to receive services and supports under Section 25.5-10-201, C.R.S. et seq , and provides authorized services and supports to such Members either directly or by purchasing such services and supports from service agencies.~~

~~E. Department means the Department of Health Care Policy and Financing.~~

~~F. Home and Community-Based Services (HCBS) means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Member who requires a level of institutional care that would otherwise be provided in an institutional setting.~~

~~G. Home and Community-Based Services Telehealth (HCBS Telehealth) is a method of service delivery of those HCBS services listed at Section 8.615.2.~~

~~H. Medicaid State Plan means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.~~

~~I. Member means as defined in Section 8.390.1.~~

~~J. Prior Authorization Request (PAR) means the Department prescribed form to authorize the reimbursement for services.~~

~~K. Person-Centered Support Plan means as defined in Section 8.390.1 DEFINITIONS.~~

~~L. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.~~

~~M. Telehealth means the broad use of technologies to provide services and supports through HCBS waivers, when the Member is in a different location from the provider.~~

~~N. Waiver Service means optional services defined in the current federally approved waiver documents and do not include Medicaid State Plan benefits.~~

~~8.615.2 INCLUSIONS~~

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~~A. HCBS Telehealth may be used to deliver support through the following authorized HCBS waiver services:~~

~~1. Adult Day Services - Basic, Tier 1; defined at Section 8.491.1;~~

~~2. Adult Day Services - Brain Injury, Tier 1; defined at Sections 8.515.3 and 8.515.70;~~

~~3. Behavioral Management and Education; defined at Section 8.516.40;~~

~~4. Behavioral Services - Behavioral Consultation; defined in Sections 8.500.5.B.1. and, 8.500.94.B.2, ;~~

~~5. Behavioral Services - Behavioral Counseling, Group, defined in Sections 8.500.5.B.1, and 8.500.94.B.2, ;~~

~~6. Behavioral Services - Behavioral Counseling, Individual, defined in Sections 8.500.5.B.1, and 8.500.94.B.2,;~~

~~7. Behavioral Services - Behavioral Plan Assessment; defined in Sections 8.500.5.B.1 and , 8.500.94.B.2,;~~

~~8. Benefits Planning; defined in Sections 8.500.5.B.2 and 8.500.94.B.3~~

~~9. Bereavement Counseling; defined at Section 8.504.1;~~

~~10. Community Connector; defined at Section 8.503.40.A.3;~~

~~11. Day Habilitation; defined at Section 8.500.5.B.2;~~

~~12. Expressive Therapy - Art and Play Therapy, Group; defined at Sections 8.504.1 and 8.504.2.D;~~

~~13. Expressive Therapy - Art and Play Therapy, Individual; defined at Sections 8.504.1 and 8.504.2.D;~~

~~14. Expressive Therapy - Music Therapy, Group; defined at Sections 8.504.1 and 8.504.2.D;~~

~~15. Expressive Therapy - Music Therapy, Individual; defined at Sections 8.504.1 and 8.504.2.D;~~

~~16. Independent Living Skills Training; defined at Section 8.516.10;~~

~~17. Mental Health Counseling, Family; defined at Section 8.516.50;~~

~~18. Mental Health Counseling, Group; defined at Section 8.516.50;~~

~~19. Mental Health Counseling, Individual; defined at Section 8.516.50;~~

~~20. Mentorship; defined at Section 8.500.94B.10;~~

~~21. Movement Therapy; defined in Sections 8.500.94B.15 and 8.503.40.A.8;~~

~~22. Palliative Supportive Care - Care Coordination; defined at Section 8.504.1;~~

~~23. Substance Abuse Counseling, Family; defined at Section 8.516.60;~~

~~24. Substance Abuse Counseling, Individual; defined at Section 8.516.60;~~

~~25. Supported Employment - Job Coaching, Individual, defined in Sections 8.500.5.B.9 and 8.500.98.C;~~

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~~26. Supported Employment - Job Development, Levels 1-6, Individual, defined in Sections 8.500.5.B.9 and 8.500.98.C;~~

~~27. Transition Services - Life Skills Training; defined at Section 8.553.1;~~

~~28. Transition Services - Peer Mentorship; defined at Section 8.553.1;~~

~~29. Therapeutic Life Limiting Illness Support, Family; defined at Sections 8.504.1 and 8.504.2.B;~~

~~30. Therapeutic Life Limiting Illness Support, Group; defined at Sections 8.504.1 and 8.504.2.B;~~

~~31. Therapeutic Life Limiting Illness Support, Individual; defined at Sections 8.504.1 and 8.504.2.B;~~

~~32. Wrap Around Service - Intensive Support; defined at Section 8.508.100.H; and,~~

~~33. Wrap Around Service - Transition Support; defined at Section 8.508.100.M;~~

~~B. HCBS Telehealth may only be used to deliver consultation for the following services:~~

~~1. Adaptive Therapeutic Recreational Fees and Equipment, defined at Section 8.503.40.A.1;~~

~~2. Assistive Technology; defined in Sections 8.500.94.B.1 and, 8.503.40.A.2;~~

~~3. Home Modification and Adaptation; defined in Sections 8.493.1, 8.500.94.B.6, and 8.503.40.A.5; and~~

~~4. Vehicle Modifications, defined in Sections 8.500.94.B.20 and 8.503.40.A.12.~~

~~5. Providers shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules and may not bill separately for consultation.~~

~~8.615.3 LIMITATIONS~~

~~A. HCBS Telehealth is subject to the limitations of the respective service it supports as referenced in this rule at Section 8.615.2.~~

~~B. HCBS Telehealth is not a duplication of Health First Colorado Telehealth or Telemedicine services.~~

~~C. HCBS Telehealth is not permitted to be used for any service not listed in this rule at Section 8.615.2.~~

~~8.615.4 PROVIDER REQUIREMENTS~~

~~A. HCBS waiver providers that choose to use HCBS Telehealth shall develop and make available a written HCBS Telehealth Policy which at a minimum shall include the following:~~

~~1. The Member may refuse telehealth delivery at any time without affecting the Member's right to any future services and without risking the loss or withdrawal of any service to which the Member would otherwise be entitled;~~

~~2. All required and applicable confidentiality protections that apply to the services;~~

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3. The Member shall have access to all collected information resulting from the services utilized as required by state law;

4. How utilization of HCBS Telehealth will be made available to those Members who require assistance with accessibility, translation, or have limited visual and/or auditory capabilities;

5. A contingency plan for service delivery if technology options fail; and,

6. HCBS waiver providers shall maintain a copy of the HCBS Telehealth Policy signed by the Member in their records.

B. HCBS waiver providers shall ensure the use of HCBS Telehealth is the choice of the Member. The HCBS waiver provider shall maintain a consent form for the use of HCBS Telehealth in the Member's record.

C. The HCBS waiver provider shall complete a provider developed evaluation of the Member and caregiver prior to using HCBS telehealth services that identifies a Member's ability to participate and outlines any accommodations needed while utilizing HCBS Telehealth.

D. HCBS waiver providers must comply with all HIPAA and confidentiality procedures. HCBS waiver providers must be able to use a technology solution that allows real-time interaction with the Member which may include audio, visual and/or tactile technologies.

E. HCBS waiver providers shall not use HCBS Telehealth to address a Member's emergency needs.

F. HCBS waiver providers shall use a HIPAA compliant technology solution meeting all privacy requirements.

8.615.5 CASE MANAGEMENT REQUIREMENTS

A. Members eligible to use HCBS Telehealth are those enrolled in the waivers and services as defined in this rule at Section 8.615.2.

B. The CMA shall ensure the use of HCBS Telehealth is the choice of the Member through the Support Planning process by indicating the Member's choice to receive HCBS Telehealth in the Department prescribed IT system.

C. Through the Support Planning process, the CMA shall identify and address the benefits and possible detriments to Members choosing to use HCBS Telehealth for service delivery.

D. HCBS Telehealth delivery must be prior authorized and documented in the Member's Support Plan.

E. Telehealth as a service delivery method for authorized HCBS waiver services, shall not interfere with any memberclient rights or be used as any part of a Rights Modification or Suspension plan.

8.615.6 REIMBURSEMENT

A. HCBS Telehealth does not include reimbursement for the purchase or installation of telehealth equipment or technologies.

B. HCBS waiver service providers utilizing Telehealth shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules. This includes the prohibition on collecting copayments or charging Members for missing set times for services.