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

8.485.30 SERVICES PROVIDED

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

A. Adult day services; and
B. Alternative care facility services, including homemaker and personal care services in a residential setting; and
C. Consumer Directed Attendant Support Services; and
D. Electronic monitoring; and
E. Home Delivered Meals; and
F. Home modification; and
G. Homemaker services; and
H. Non-medical transportation; and
I. Peer Mentorship; and
J. Personal care; and
K. Respite care; and
L. Transition Independent Living Skills Training; and
M. Transition Setup.
N. In-Home Support Services; and
O. ~~Community Transition Services; and~~
P. Consumer Directed Attendant Support Services.

8.485.40 DEFINITIONS OF SERVICES

A. Adult day services shall be as defined at 10 CCR 2505-10 section 8.491.
B. Alternative Care Facility services shall be as defined at 10 CCR 2505-10 section 8.495.
C. Electronic monitoring services shall be as defined at 10 CCR 2505-10 section 8.488.
D. Home Delivered Meals services shall be defined at 10 CCR 2505-10 section 8.553
E. Home modification shall be as defined at 10 CCR 2505-10 section 8.493.
F. Homemaker services shall be as defined at 10 CCR 2505-10 section 8.490.
G. Non-medical transportation services shall be as defined at 10 CCR 2505-10 section 8.494.
H. Peer Mentorship services shall be defined at 10 CCR 2505-10 section 8.553
I. Personal care services shall be as defined at 10 CCR 2505-10 section 8.489.
J. Respite care shall be as defined at 10 CCR 2505-10 section 8.492.
K. Transition Independent Living Skills Training (T-ILST) services shall be defined at 10 CCR 2505-10 section 8.553.
L. Transition Setup services shall be defined at 10 CCR 2505-10 section 8.553.
M. In-Home Support Services shall be as defined at 10 CCR 2505-10 section 8.552.
N. ~~Community Transition Services (CTS) shall be as defined at 10 CCR 2505-10 section 8.553.~~
O. Consumer Directed Attendant Support Services (CDASS) shall be defined at 10 CCR 2505-10 section 8.510.

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

8.500.5 HCBS-DD WAIVER SERVICES

8.500.5.A SERVICES PROVIDED

A. Behavioral Services

B. Day Habilitation Services and Supports

C. Dental Services

D. Non-Medical Transportation

E. Residential Habilitation Services and Supports (RHSS)

F. Specialized Medical Equipment and Supplies

G. Supported Employment

H. Vision Services

I. Transition Setup

J. Home Delivered Meals

K. Peer Mentorship

8.500.5.~~A.~~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.

9. Transition Setup services shall be defined at 10 CCR 2505-10, 8.553.

10. Home Delivered Meals services shall be defined at 10 CCR 2505-10 section 8.553.

11. Peer Mentorship services shall be defined at 10 CCR 2505-10 section 8.553.

8.500.94 HCBS-SLS WAIVER SERVICES

8.500.94.A SERVICES PROVIDED

A. Assistive Technology

B. Behavioral Services

C. Day Habilitation services and supports

D. Dental Services

E. Home Accessibility Adaptations

F. Homemaker Services

G. Mentorship

H. Non-Medical Transportation

I. Personal Care

J. Personal Emergency Response System (PERS)

K. Professional Services, defined below in 8.500.94.B.

L. Respite

M. Specialized Medical Equipment and Supplies

N. Supported Employment

O. Vehicle Modifications

P. Vision Services

Q. Transition Independent Living Skills Training (T-ILST)

R. Transition Setup

S. Home Delivered Meals

T. Peer Mentorship

8.500.94.~~A.~~B. DEFINITIONS OF SERVICES

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

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

    a. Assistance in interviewing potential providers,
    b. Assistance in understanding complicated health and safety issues,
    c. Assistance with participation on private and public boards, advisory groups and commissions, and
    d. Training in child and infant care for clients who are parenting children.
    e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.

f. Mentorship services are limited to one hundred and ninety two (192) units (forty eight (48) hours) per service plan year. One (1) unit is equal to fifteen (15) minutes.
g. Units to provide training to clients for child and infant care shall be prior authorized beyond the one hundred and ninety two (192) units per service plan year in accordance with Operating Agency procedures.
h. Mentorship services are distinct from Peer Mentorship services, which are defined at 10 CCR 2505-10 section 8.553.

18. Transition Independent Living Skills Training (T-ILST) services shall be defined at 10 CCR 2505-10 section 8.553.
19. Transition Setup services shall be defined at 10 CCR 2505-10 section 8.553.
20. Home Delivered Meals services shall be defined at 10 CCR 2505-10 section 8.553.
21. Peer Mentorship services shall be defined at 10 CCR 2505-10 section 8.553.

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

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 C.R.S. 25.5-6-1101, et seq. (2014).

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 10 CCR 2505-10 §8.500.94.B.10
    ii) Homemaker as defined at Section 10 CCR 2505-10 §8.500.94.B.6
    iii) Health Maintenance Activities as defined at Section 10 CCR 2505-10 §8.500.94.B.17
3. The case manager shall conduct the case management functions SET FORTH at section 8.510.14 et. seq.

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

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

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

1. Adult Day Services
2. Alternative Care Facility Services (which includes Homemaker and Personal Care services)
3. Consumer Directed Attendant Support Services (CDASS)
4. Electronic Monitoring
5. Home Delivered Meals
6. Home Modification
7. Homemaker Services
8. Non-Medical Transportation
9. Peer Mentorship
10. Personal Care
11. Respite Care
12. Transition Independent Living Skills Training (T-ILST)
13. Transition Setup

8.509.13 DEFINITIONS OF SERVICES

A. Adult Day Services is defined at Section 8.491, ADULT DAY SERVICES.

B. Alternative Care Facility Services is defined at Section 8.495, ALTERNATIVE CARE FACILITY.

C. Consumer Directed Attendant Support Services (CDASS) is defined at Section 8.510, CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES.

D. Electronic Monitoring services is defined at Section 8.488, ELECTRONIC MONITORING.

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

F. Home Modification is defined at Section 8.493, HOME MODIFICATION.

G. Homemaker Services is defined at Section 8.490, HOMEMAKER SERVICES.

H. Non-Medical Transportation is defined at Section 8.494, NON-MEDICAL TRANSPORTATION.

I. Peer Mentorship services shall be defined at 10 CCR 2505-10 section 8.553.

J. Personal Care is defined at Section 8.489, PERSONAL CARE.

K. Respite is defined at Section 8.492, RESPITE

L. Transition Independent Living Skills Training (T-ILST) services shall be defined at 10 CCR 2505-10 section 8.553.

M. Transition Setup services shall be defined at 10 CCR 2505-10 section 8.553.

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

8.515.2 DEFINITIONS OF SERVICES PROVIDED

A. Adult Day Services means services as defined at Section 8.515.70

B. Behavioral Programming and Education means services as defined at Section 8.516.40.

C. Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510

D. Counseling Services means services as defined at Section 8.516.50.

E. Day Treatment means services as defined at Section 8.515.80.

F. Electronic Monitoring Services means services as defined at Section 8.488.

G. Home Delivered Meals services shall be defined at 10 CCR 2505-10 section 8.553.

H. Home Modification means services as defined at Section 8.493.

I. Independent Living Skills Training (ILST) means services as defined at Section 8.516.10.

J. Non-Medical Transportation Services means services as defined at Section 8.494.

K. Peer Mentorship services shall be defined at 10 CCR 2505-10 section 8.553.

L. Personal Care means services as defined at Section 8.489.

M. Respite Care means services as defined at Section 8.516.70.

N. Specialized Medical Equipment and Supplies means services as defined at Section 8.515.50.

O. Substance Abuse Counseling means services as defined at Section 8.516.60.

P. 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.

Q. Transitional Living Program means services as defined at Section 8.516.30.

R. Transition Setup services shall be defined at 10 CCR 2505-10 section 8.553.

8.516.10 INDEPENDENT LIVING SKILLS TRAINING

D. REIMBURSEMENT

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

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

8.517.1 DEFINITIONS OF SERVICES PROVIDED

A. Adult Day Services means services as defined at Section 8.491.

B. Complementary and Integrative Health Services means services as defined at Section 8.517.11.

C. Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.

D. Electronic Monitoring means services as defined at Section 8.488.

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

F. Home Modification means services as defined at Section 8.493.

G. Homemaker Services means services as defined at Section 8.490.

H. In-Home Support Services means services as defined at Section 8.552.

I. Non-Medical Transportation means services as defined at Section 8.494.

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

K. Personal Care Services means services as defined at Section 8.489.

L. Respite Care means services as defined at Section 8.492.

M. Transition Independent Living Skills Training services shall be defined at 10 CCR 2505-10 section 8.553.

N. Transition Setup services shall be defined at 10 CCR 2505-10 section 8.553.

8.553 TRANSITION SERVICES

8.553.1 GENERAL DEFINITIONS

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

2. **Case Management Agency** means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the state department to provide case management services for Home and Community Based Services Waivers pursuant to Colo. Rev. Stat. § 25.5-10-209.5 and to Colo. Rev. Stat. § 25.5-6- 106. The case management agency shall provide case management services pursuant to a provider participation agreement with the state department.

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

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

5. **Home and Community Based Services (HCBS) Waivers** means services and supports authorized through a 1915(c) waiver of the social security act and provided in community settings to a client who requires an institutional level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

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

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

8. **Peer Mentorship** means support provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to

community living, describing real-world experiences as examples, and modeling successful community living and problem-solving.

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

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

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

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

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

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

15. **Transition Independent Living Skills Training (T-ILST)** means supports for a client transitioning from a nursing home, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to the community through individualized training designed and directed with the client to develop and maintain their ability to independently sustain themselves—physically, emotionally, socially and economically—in the community. T-ILST may be provided in the client's residence, in the community, or in a group living situation.

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

17. **Transition Independent Living Skills Training (T-ILST) Trainers** means individuals who are trained in accordance with guidelines listed below tasked with providing T-ILST to the program client.

18. **Transition Period** means the period of time in which the client receives TCM-TS for the purpose of successful integration into community living. A transition period is completed when the client

has successfully established community residence and is no longer in need of TCM-TS based on the risk mitigation plan.

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

20. **Transition Services** means services to support a successful transition from a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) to a non-Regional Center HCBS setting, or from an HCBS Regional Center placement to a less restrictive HCBS setting.
21. **Transition Setup Authorization Request Form** is a formal document delineating and requesting the authorization of payment for the items and/or services required for the transition set up to occur. This document is submitted to the Case Management Agency.

22. **Transition Setup Coordination** means the coordination and purchase of one-time, non-recurring expenses necessary for a client to establish a basic household as they transition from a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) to a non-Regional Center HCBS setting, or from an HCBS Regional Center placement to a less restrictive HCBS setting.

23. **Transition Setup Expense** are non-recurring set-up expenses for clients who are transitioning from a nursing home, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to establish an independent living arrangement. Set-up expenses are those necessary to enable a person to establish a basic household that do not constitute room and board.

8.553.2 SERVICE ACCESS AND AUTHORIZATION

1. Transition Independent Living Skills Training (T-ILST) means supports for a client transitioning from a nursing home, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to the community through individualized training designed and directed with the client to develop and maintain their ability to independently sustain themselves—physically, emotionally, socially and economically—in the community. T-ILST may be provided in the client's residence, in the community, or in a group living situation.

2. A person accessing transition services must:

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

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

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

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

e. Work with the Case Management Agency to:

i. Select the services needed for a successful transition through the eligible HCBS Waivers.

ii. Obtain authorization of the HCBS services in accordance with the Transition Plan developed by the Transition Options Team (TOT) in accordance with the Department's rule at 8.519.27.B.

3. Unless specified otherwise, transition services are available, based on need, up to 365 days post-transition.

4. Services available include:

a. Transition Independent Living Skills Training (T-ILST) as defined in 10 CCR 2505-10, section 8.553.3.

i. T-ILST Is available in the HCBS-CMHS Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.509.12.

ii. T-ILST Is available in the HCBS-EBD Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.485.30.

iii. T-ILST Is available in the HCBS-SCI Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.517.1.

iv. T-ILST Is available in the HCBS-SLS Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.500.94.

b. Transition Setup as defined in 10 CCR 2505-10, section 8.553.4.

i. Transition Setup is available in the HCBS-BI Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.515.2.

ii. Transition Setup is available in the HCBS-CMHS, as indicated in the Department's rule at 10 CCR 2505-10, section 8.509.12.

iii. Transition Setup is available in the HCBS-DD Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.500.5.

iv. Transition Setup is available in the HCBS-EBD Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section8.485.30.

v. Transition Setup is available in the HCBS-SCI Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.517.1.

vi. Transition Setup is available in the HCBS-SLS Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.500.94.

c. Home Delivered Meals as defined in 10 CCR 2505-10, section 8.553.5.

i. Home Delivered Meals is available in the HCBS-BI Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.515.2.

ii. Home Delivered Meals is available in the HCBS-CMHS Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.509.12.

iii. Home Delivered Meals is available in the HCBS-DD Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.500.5.

iv. Home Delivered Meals is available in the HCBS-EBD Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.485.30.

v. Home Delivered Meals is available in the HCBS-SCI Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.517.1.

vi. Home Delivered Meals is available in the HCBS-SLS Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.500.94.

d. Peer Mentorship as defined in 10 CCR 2505-10, section 8.553.6.

i. Peer Mentorship is available in the HCBS-BI Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.515.2.

ii. Peer Mentorship is available in the HCBS-CMHS Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.509.12.

iii. Peer Mentorship is available in the HCBS-DD Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.500.5.

iv. Peer Mentorship is available in the HCBS-EBD Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.485.30.

v. Peer Mentorship is available in the HCBS-SCI Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.517.1.

vi. Peer Mentorship is available in the HCBS-SLS Waiver, as indicated in the Department's rule at 10 CCR 2505-10, section 8.500.94.

8.553.3 TRANSITION INDEPENDENT LIVING SKILLS TRAINING (T-ILST)

Transition Independent Living Skills Training (T-ILST) means supports for a client transitioning from a nursing home, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to the community through individualized training designed and directed with the client to develop and maintain their ability to independently sustain themselves—physically, emotionally, socially and economically—in the community. T-ILST may be provided in the client's residence, in the community, or in a group living situation.

A. INCLUSIONS

1. Reimbursable services are limited to the assessment, training, maintenance, supervision, assistance, or continued supports of the following skills training:

a. Problem-solving transition-related issues;

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

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

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

e. Household management;

f. Time management skills training;

g. Safety awareness skill development and training;

h. Task completion skill development and training;

i. Communication skill building;

j. Interpersonal skill development;

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

l. Recreation, including leisure and community engagement;

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

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

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

p. Skills training may include training for assistive technology when appropriate and not duplicative.

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

B. LIMITATIONS AND EXCLUSIONS

1. Clients may utilize T-ILST up to 24 units (six hours) a day, for no more than 160 units (40 hours) a week, up to 365 days post-transition.

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

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

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

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

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

C. PROVIDER STANDARDS

1. PROVIDER QUALIFICATIONS

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

i. The provider has a Home Care Agency Class A or B license from the Colorado Department of Public Health and Environment (CDPHE); or

ii. Enrolled providers shall be considered existing providers if they have provided and billed, Independent Living Skills Training services, prior to December 31, 2018 through the Colorado Choice Transitions (CCT), a Money Follows the Person demonstration as outlined in the Department's rule at 10 CCR 2505-10, section 8.555. Existing providers may provide T-ILST services through December 31, 2019, without Home Care Agency Class A or B licensure and recommendation for T-ILST certification from CDPHE, with the following limitation:

1. On or after July 1, 2019, an existing provider shall not manage and offer, directly or by contract, T-ILST services or operate or maintain a T-ILST Agency without having submitted a completed application for Class A or B licensure to CDPHE.

b. The Department of Public Health and Environment recommends to the Department of Health Care Policy and Financing that the provider be certified as a T-ILST provider; and

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

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

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

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

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

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

i. Any component of the ILST plan that may contain activities outside the scope of the ILST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the client. These professionals must be in good standing as one of the following:

    b. Occupational Therapist;

    c. Physical Therapist;

    d. Registered Nurse;

    e. Speech Language Pathologist;

    f. Psychologist;

    g. Neuropsychologist;

    h. Medical Doctor;

    i. Licensed Clinical Social Worker;

    j. Licensed Professional Counselor; or

    k. Board Certified Behavior Analyst (BCBA)

j. Professionals providing components of the T-ILST plan can include individuals who are agency staff, contracted staff, or external licensed and certified professionals who are fully aware of duties conducted by T-ILST trainers; and

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

b. T-ILST Trainer

    i. T-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's 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 T-ILST services; or

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

c. The agency shall administer a series of training programs to all T-ILST trainers.

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

a. Person-centered support approaches; and

b. HIPAA and client confidentiality; and

c. Basics of working with the population to be served; and

d. On-the-job coaching by an incumbent T-ILST trainer; and

e. Basic safety and de-escalation techniques; and

f. Training on community and public resource availability; and

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

ii. T-ILST trainers must also receive ongoing training, required within 90 days of unsupervised contact and annually, in the following areas:

a. Cultural awareness; and

b. Updates on working with the population to be served; and

c. Updates on resource availability.

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

D. DOCUMENTATION

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

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

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

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

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

ii. Nature and extent of service; and

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

iv. Progress toward Service Plan goals and objectives; and

v. Provider's signature and date.

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

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

E. REIMBURSEMENT

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

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

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

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

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

8.553.4 TRANSITION SETUP

Transition Setup means the coordination and purchase of one-time, non-recurring expenses necessary for a client to establish a basic household as they transition from a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) to a non-Regional Center HCBS setting, or from an HCBS Regional Center placement to a less restrictive HCBS setting. Transition Setup includes two component services: Transition Setup Coordination and Transition Setup Expense.

A. INCLUSIONS

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

2. The Transition Setup Expense is for the purchase of one-time, non-recurring expenses necessary for a client to establish a basic household as they transition from a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) to a non-Regional Center HCBS setting, or from an HCBS Regional Center placement to a less restrictive HCBS setting. Allowable expenses include:

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

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

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

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

    e. A one-time purchase of basic pantry essentials not to exceed $250.

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

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

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

B. LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

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

C. PROVIDER STANDARDS

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

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

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

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

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

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

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

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

D. DOCUMENTATION

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

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

a. Transition Services Referral Form

b. Release of Information (confidentiality) Forms

c. Transition Setup Authorization Request Form

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

E. REIMBURSEMENT

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

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

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

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

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

8.553.5 HOME DELIVERED MEALS

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

F. INCLUSIONS

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

3. Clients may utilize Home Delivered Meals over a period of 365 days post-transition for the purposes of transitioning from a qualified nursing home, ICF/IID, or Regional Center location to the community.

4. Meals are to be delivered face-to-face up to two meals per day or 14 meals delivered one day per week.

G. SERVICE AUTHORIZATION

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

a. Meeting with a certified Registered Dietician (RD) or Registered Dietician Nutritionist (RDN) for individualized nutritional counselling and developing an individualized

Nutritional Meal Plan, which specifies the client's nutritional needs, selected meal types, and instructions for meal preparation and delivery; and

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

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

3. Meals may be ethnically or culturally-tailored.

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

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

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

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

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

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

H. LIMITATIONS AND EXCLUSIONS

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

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

3. This service is not available to a client who pays a standard room and board fee, as meals are the responsibility of the Agency that receives the board fee payment.

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

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

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

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

I. PROVIDER STANDARDS

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

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

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

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

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

5. The provider shall have all licensures required by the State of Colorado Department of public health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff; and

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

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

J. DOCUMENTATION

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

    a. Signed authorization from appropriate licensed professional for dietary restrictions or specific nutritional needs; and

    b. Consumer demographic information; and

    c. Meal Delivery Schedule; and

    d. Documentation of special diet requirements; and

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

    f. Date and place of service delivery; and

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

    h. Provision of nutrition counseling; and

i. Maintenance of appropriate documentation.

K. REIMBURSEMENT

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

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

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

8.553.6 PEER MENTORSHIP

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

A. INCLUSIONS

1. Problem-solving transition-related issues drawing from shared experience.

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

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

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

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

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

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

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

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

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

B. LIMITATIONS AND EXCLUSIONS

1. Limited to up to 365-days post-transition.

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

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

C. PROVIDER STANDARDS

1. Provider Qualifications

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

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

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

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

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

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

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

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

i. Meets the qualification standards designated in the Colorado Peer Mentorship Manual.

ii. Has achieved a Certificate of Completion of the Peer Mentorship Training curriculum designated in the Colorado Peer Mentorship Manual.

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

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

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

D. DOCUMENTATION

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

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

b. Nature and extent of service; and

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

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

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

f. Progress toward Service Plan goals and objectives; and

g. Provider's signature and date.

8. REIMBURSEMENT

a. Peer Mentorship services billed in 15 minute units.

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

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

~~**8.553 COMMUNITY TRANSITION SERVICES**~~

~~**8.553.1 DEFINITIONS**~~

~~Authorization Request (AR) means a request submitted by the Transition Coordination Agency to the Single Entry Point agency to authorize payment for delivery of Community Transition Services.~~

~~Case Management means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic assessment of such client's needs.~~

~~Case Management Agency means the organization selected to provide case management functions for person in need of long term care services.~~

~~Community Transition Services (CTS) means activities essential to move a client from a skilled nursing facility and establish a community-based residence.~~

~~Independent Living Core Services means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; and individual and systems advocacy.~~

~~Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Case Management.~~

~~Transition Coordination Agency (TCA) means an agency that is certified by the Department to provide CTS and provides at least two Independent Living Core Services.~~

~~Transition Options Team means a group of individuals, chosen by the client and/or providing services to the client, who participate in the transition assessment and planning process.~~

~~8.553.2 BENEFITS~~

~~8.553.2.A. CTS shall only be available to clients currently residing in a skilled nursing facility or an Intermediate Care Facility Individuals with Intellectual Disabilities (ICF-IID) who are eligible for adult Home and Community- Based Services (HCBS) waivers except the Spinal Cord Injury Waiver.~~

~~8.553.2.B. CTS includes transition coordination services and funds to assist the client to set-up a household.~~

~~8.553.2.C. CTS shall be provided by Transition Coordinators who are employed by Transition Coordination Agencies certified by the Department.~~

~~8.553.2.D. CTS shall be provided using procedures and guidelines provided in the Department transition coordination and intensive case management training.~~

~~8.553.2.E. The CTS household set-up assistance shall only be for the benefit of the client to set up a less restrictive living arrangement and may include the following:~~

~~1. Security deposits that are required to obtain a lease on a residence.~~
~~2. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.~~
~~3. Essential household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items.~~
~~4. Moving expenses required to occupy a community-based residence.~~
~~5. Health and safety assurances including a one-time pest eradication and one-time cleaning prior to occupancy.~~
~~6. A one-time purchase of food not to exceed $100.~~
~~7. Purchase of a cell phone to be used for safety monitoring.~~
~~8. First month rent.~~
~~9. Bus pass for period that covers the time period from referral to CTS to 30 days past the date of discharge from a facility described at 10 C.C.R. 2505-10, Section 8.553.2.A.~~
~~10. Computer that is determined to be medically necessary to sustain a less restrictive living arrangement. (Client is required to complete computer training prior to receiving computer).~~
~~11. Clothing that is appropriate for the community.~~

~~8.553.2.F. The cost of CTS shall not exceed the established amount per client unless otherwise authorized by the Department.~~

~~8.55.3.2.G. Items purchased through CTS, returned security deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.a. and returned deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.b. shall be the property of the client. The client may take the property with him or her in~~

~~the event of a move to another residence.~~

~~**8.553.3 NON-BENEFITS**~~

~~8.553.3.A. CTS shall not include the following:~~
~~1. Monthly rental expenses or other ongoing periodic residential expenses.~~
~~2. Recreation, entertainment or convenience items.~~
~~3. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.E when already provided through other means.~~
~~4. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.E when provided for the benefit of persons other than the client.~~
~~5. Monthly cell phone expenses.~~
~~6. Monthly bus pass expenses not described in 10 C.C.R. 2505-10, Section 8.553.2.E.i.~~

~~**8.553.4 TCA QUALIFICATIONS**~~

~~8.553.4.A. A TCA shall conform to all certification standards and procedures described in 10 C.C.R. 2505-10, Section 8.487, HCBS-EBD Provider Agencies.~~

~~8.553.4.B. A TCA shall meet all requirements as set forth in 10 C.C.R. 2505-10, Section 8.553.5.~~

~~**8.553.5 TCA RESPONSIBILITIES**~~

~~8.553.5.A. TCAs shall administer the CTS benefit.~~

~~8.553.5.B. The TCA shall perform administrative functions, including supervision of Transition Coordinators, attendance at required meetings, timely reporting, compliance with transition procedures defined by the Department with input from stakeholders, community coordination and outreach, client monitoring and on-site visits.~~

~~8.553.5.C. Staffing Requirements~~
~~1. The TCA shall ensure and document that each Transition Coordinator has completed the required Department Transition Coordinator training and has received a satisfactory proficiency rating.~~
~~2. The TCA shall ensure that each Transition Coordinator has received training in the following:~~
~~a. Knowledge of populations served by the TCA and the target population served by waivers.~~
~~b. Client interviewing and assessment skills.~~
~~c. Intervention and interpersonal communication skills.~~
~~d. Knowledge of available community resources and public assistance programs.~~
~~e. Team coordination skills.~~
~~f. Meeting facilitation skills.~~
~~3. The TCA supervisor(s), at a minimum, shall have two years supervisory experience and meet all qualifications for a Transition Coordinator.~~
~~4. The TCA supervisor shall complete the Department transition coordination supervision training.~~
~~5. Supervision of Transition Coordinators shall include, but not be limited to, the following activities:~~
~~a. Arrangement and documentation of training or skills validation testing.~~
~~b. Review of transition assessments and plans and risk mitigation plans.~~
~~c. Oversight of transition coordination activities.~~
~~d. Assessment of client's satisfaction with services.~~
~~e. Investigation of complaints regarding provision of CTS.~~
~~f. Counseling with staff on difficult cases.~~
~~g. Oversight of recordkeeping by staff.~~

6. Training shall be completed prior to the delivery of CTS.

8.553.5.D. The Transition Coordinator shall conduct transition activities in accordance with training, policies and procedures defined by the Department.

8.553.5.E. The Transition Coordinator shall work with the client to create and implement a transition plan agreed upon by the Transition Coordinator and the client. The Transition Coordinator and the client shall sign the transition plan to signify agreement.
1. The Transition Coordinator shall submit the signed transition plan to the client's Single Entry Point (SEP) case manager for approval prior to plan implementation.
2. The plan shall include the items needed for the client to transition to a community based residence. If after the plan has been approved the Transition Coordinator determines additional purchases are required, the Transition Coordinator shall submit a plan revision for approval prior to the purchases.

8.553.5.F. The Transition Coordinator shall work with the client to obtain a residence and any items necessary to establish a community based residence.

8.553.5.G. The Transition Coordinator shall conduct a minimum of four on-site visits of the residence to ensure all essential furnishings, utilities, community resources and services are in place. If the Transition Coordinator finds any of the supports to be insufficient for the client to successfully live in the community, the Transition Coordinator shall correct the deficiencies. The on-site visits shall occur at the following intervals:
1. Prior to the client's discharge from the skilled nursing facility.
a. If possible, the client shall accompany the Transition Coordinator during the onsite visit prior to discharge. If the client is unable to participate in the on-site visit, the Transition Coordinator shall document the reason in the client's file.
2. The day of the move.
3. One week after the transition to ensure the client has the proper supports to continue successfully living in the community.
4. One month after the transition to ensure the client has the proper supports to continue successfully living in the community.

8.553.6 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES

8.553.6.A. The SEP case manager shall perform a review to assure all items in the transition plan meet the criteria of the benefit described in 8.553.2.
1. The SEP case manager shall complete a review of the transition plan and shall notify the TCA of approval or denial of the plan within ten business days of receipt.

8.553.7 AUTHORIZATION REQUESTS

8.553.7.A. The TCA shall submit the Department prescribed Authorization Request (AR) form to the SEP case manager to authorize payment for CTS.
1. The TCA shall only submit the AR to authorize payment for any purchases or deposits after the client transitions to the community. The AR shall include a Department-approved cost report including copies of cancelled checks and copies of receipts detailing the items purchased and the cost.
a. Any expenses submitted on the cost report for items that are not included in the approved transition plan shall be considered non-allowable expenses and shall not be reimbursed.
b. The SEP case manager shall complete a review of the AR and the cost report and shall notify the TCA of approval or denial of the AR and if applicable, any non-allowable expenses on the cost report within ten business days of receipt.
2. The TCA shall only submit the AR for Transitional Case Management once the Transition Coordinator has conducted the on-site visit one month after the client's transition.

~~a. The SEP case manager shall approve the AR only after verifying that the client is established in a community-based residence.~~
~~b. The SEP case manager shall complete a review of the AR and shall notify the TCA of approval or denial within ten business days of receipt.~~

~~8.553.7.B. The SEP case manager shall complete a review of the AR and the cost report within ten business days of receipt. The SEP case manager shall notify the TCA of approval of the AR and if applicable, any non-allowable expenses on the cost report.~~
~~1. Approval of the AR by the SEP case manager shall authorize the TCA to submit claims to the Department's fiscal agent for authorized CTS provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the TCA's use of correct billing procedures.~~

~~8.553.7.C. Incomplete ARs shall be returned to the TCA for correction within ten business days of receipt by the SEP agency.~~

~~8.553.8 REIMBURSEMENT~~

~~8.553.8.A. The TCA shall conform to all reimbursement procedures described in 10 C.C.R. 2505-10, Section 8.487.200 Provider Reimbursement.~~

~~8.553.8.B. Payment for CTS shall be the lower of the billed charges or the maximum rate of reimbursement.~~

~~8.553.8.C. The cost of Transitional Case Management shall be reimbursed by one unit of service completed when the client is established in a community-based residence as verified by the SEP case manager.~~

~~8.553.8.D. Reimbursement shall be made only for items listed on the transition plan with an accompanying receipt.~~