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8.7400 Provider Agency Requirements

8.7400 Home and Community Based Services Provider Agency Requirements

8.7401 Statement of Purpose and Scope

A. The purpose of this Section 8.7400 is to outline requirements for Home and Community Based Services (HCBS) provider agencies. These rules apply to all HCBS waivers.

8.7402 Definitions

1. Case Manager is as defined in Section 8.7202.
2. Case Management Agency (CMA) is as defined in Section 8.7101.8.
3. Certification means a determination made by the Department, after considering a recommendation from the state survey agency, that a Provider Agency is compliant with applicable Department statutes, rules, and program requirements for specific Home and Community Based Services.
4. Contractor means an individual who performs work on behalf of a provider agency but is not an employee of the agency.
5. Department is as defined in Section 8.7202.
6. Direct Care Worker means a non-administrative employee or independent contractor of a Provider Agency or Consumer Directed Attendant Support Services employer who provides hands-on care, services, and support to older adults and individuals with disabilities across the long-term services and supports continuum within home and community-based settings.
7. Discrimination is defined at Section 8.7002.C.
8. Guardian is as defined at Section 8.7101.33.
9. Health First Colorado means the state Medicaid program providing public health insurance for qualifying Coloradans.
10. Home and Community Based Services waivers are as defined at Section 8.7101.35.
11. Incident means an actual or alleged event that creates the risk of harm and/or endangers or negatively impacts the mental and/or physical health, well-being, or welfare of a member.
12. An Incident means an event or occurrence that may endanger or negatively impact the mental and/or physical well-being of a member.
13. Intellectual and Developmental Disability is defined at Section 8.7101.40.
14. Legally Authorized Representative is defined at Section 8.7002.F
15. Member is defined at Section 8.7202.22.
16. Medicaid means Health First Colorado, the Colorado state Medicaid program.
17. Organized Health Care Delivery System (OHCDS) means a Case Management Agency (CMA) that contracts with other qualified providers to furnish services authorized in any of the Home and Community-Based Services waivers. The OHCDS is the Medicaid provider of record for a member whose services are delivered through the OHCDS.
18. Prior Authorization Request (PAR) means a request submitted to either the Case Management Agency or the Department prior to rendering services for authorization to provide and bill for an item or service for a member.
19. Protected Health Information (PHI) means individually identifiable health information, including, without limitation any information, whether oral or recorded in any form or medium that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a

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reasonable basis to believe the information can be used to identify the individual. PHI includes, but is not limited to, any information defined as Individually Identifiable Health Information pursuant to 42 C.F.R. § 160.103.

20. Plain Language means communication the audience can understand the first time they read or hear it and is characterized by being clear, concise, well-organized, and following other best practices appropriate to the subject or field and intended audience.
21. Provider Agency means an agency which has a contract with the Department to provide one or more of the services listed within Section 8.7500, et seq.
22. Provider Participation Agreement means the contract between the Department and the Provider that describes the terms and conditions governing participation in the programs administered by the Department.
23. Provider Specialty means a service that an HCBS provider may deliver and be reimbursed for upon meeting the service-specific qualifications and enrolling through the Department's Fiscal Agent.
24. Telehealth means the provision of health care remotely using telecommunications technologies to provide approved services and supports through HCBS waivers when the Member is in a different location from the provider.

8.7403 Provider Certification, Decertification and Termination

A. Certification
   1. For services that require HCBS certification, provider agencies shall obtain certification prior to rendering or billing for services.
   2. A provider agency seeking HCBS certification must submit a request to the Department or its agent.
   3. Upon receipt of the request, the Department or its agent shall forward certification information and relevant state application forms to the requesting agency.
   4. 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.
   5. 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; and
      c. If appropriate, a corrective action plan to satisfy the requirements of a provisional approval.
   6. Determination of certification approval, provisional approval, or denial shall be made by the Department after the completed application is submitted by the agency.

B. Change in Information
   1. Provider agencies shall notify the Department of any material or substantial change in information contained in the enrollment application given to the Department by the provider agency. This notification shall be made in the Provider Portal within 35 calendar days of the event triggering the reporting obligation. A material or substantial change includes a change in ownership; disclosures; licensure; federal tax identification number, bankruptcy; address, telephone number, or email address; criminal convictions related to involvement in any Medicare, Medicaid or Social Security Act, Title XX Health Services Block Grant program; or change in Geographic Service Area.
   2. Pursuant to Section 8.130.45, provider agencies shall notify the Department within 35 calendar days of the loss or termination of certification and/or licensure that is required for Home and

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Community Based Services provider enrollment. The notification shall be submitted through the Provider Portal as a maintenance application to terminate the providers' enrollment of a specialty or as a Medicaid provider.

C. Decertification
   1. The Department may decertified a provider if any of the following occur:
      a. The Provider agency fails to comply with any federal or state statute, rules, or guidance.
      b. The Provider agency fails to comply with any lawful requests by the Department or its agents.
      c. The Provider agency is no longer eligible to provide the services for which the provider has received certification.
      d. The Provider agency poses a threat to the health, safety, or welfare of Medicaid members.
   2. Decertification may occur without prior notice if the decertification is imperatively necessary for the preservation of the public health, safety or welfare and observance of this notice requirement would be contrary to the public interest. For any decertification action taken without prior notice, the Department shall issue a written notice of decertification within five business days of the action.
   3. If the provider agency elects to dispute the decertification, the Department must receive the provider's written request to dispute the decertification within thirty (30) calendar days of the date of the decertification notice or the dispute will not be considered.
   4. The Department's determination on the decertification dispute shall include a statement of the provider's appeal rights set forth in Section 8.050.
   5. The effective date of the inactivation may be backdated to the date of the occurrence described above.

8.7404 Change of Ownership

A. Certified providers and those licensed by Colorado Department of Public Health and Environment (CDPHE) that are undergoing a change of ownership (CHOW) shall complete both the CDPHE CHOW process and the Department's CHOW process concurrently.

B. A CHOW resulting in a change of Federal Employer Identification Number (EIN) terminates the original owner's Provider Participation Agreement. The new owners shall submit a new enrollment application through the Provider Enrollment Portal that includes the original owner's information, the new owner's EIN, and a new Provider Participation Agreement. The change of ownership enrollment application cannot be processed for approval until the original owner completes and submits a voluntary disenrollment request through the Provider Web Portal.
   1. The new owner shall meet licensing, certification, and approval process standards prior to enrollment.

8.7405 Documentation

A. In addition to the documentation required by 8.130.2, HCBS provider documentation shall also include:
   1. Location of service provided;
   2. Time and date service was provided, including beginning and end time;
   3. Name of individual rendering service;
   4. Service(s) rendered, and the exact nature of the specific tasks performed that align with the service definition(s) in 8.7500.
   5. Documentation of any changes in the member's condition or needs and action taken because of the changes; and
   6. Units of service provided.
   7. For per-diem services, documentation of services rendered shall include:

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a. Medication Administration Record (MAR) if applicable;
b. Daily attendance tracker;

8. Weekly notes shall include:
   a. Activities member participated in;
   b. Appointments if applicable; and
   c. Respite services or overnight stays elsewhere if applicable.

8.7406 Insurance Requirements

A. Provider agencies shall maintain liability insurance in an amount sufficient to cover total bodily injury or property damage liability arising from a single incident.
B. Provider agencies managing personal needs funds shall obtain an appointment from the Social Security Administration to serve as a Representative Payee and comply with all licensing and bonding requirements.
C. Provider agencies rendering reimbursable Non-Medical Transportation (NMT) services shall maintain liability insurance with the following automobile liability minimum limits:
   1. Bodily injury (BI) $300/$600K per person/per accident; and
   2. Property damage $50,000, or
   3. $500,000 combined single limit
D. Drivers who utilize their personal vehicle on behalf of a provider agency to provide reimbursable NMT shall maintain the following minimum automobile insurance coverage, 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.

8.7407 HCBS Provider Billing

A. Claims for HCBS services are payable only if submitted in accordance with the following procedures:
   1. Provider agencies shall verify member eligibility prior to delivering services;
   2. Provider agencies shall verify a PAR has been approved for the services in question, prior to service provision and claim submission;
   3. Claims shall be submitted to the Fiscal Agent in accordance with Department billing manuals and policies, outlined in Section 8.043;
   4. Claims shall only be submitted for services the provider is enrolled to provide, including correct HCBS specialties;
   5. Claims shall only be submitted for services provided in accordance with all applicable federal and state statutes, regulations, and other authorities;
   6. Submitted claims shall include all data elements required to complete the National Uniform Claim Committee Form 1500 (CMS 1500).
B. Payment shall not exceed rate shown in the Health First Colorado Fee Schedule in effect on the date services are provided.
C. Pursuant to § 25.5-4-301, C.R.S., provider agencies shall not collect copayments or seek reimbursement from eligible members for services for covered services.
   1.

8.7408 Policies and Procedures

A. Provider agencies shall establish and maintain policies and procedures for each of the items below.
   1. Staffing and employment
      a. Provider agencies shall have written policies and procedures for recruiting, selecting, orienting, training, ~~retaining~~, and terminating employees and contractors. Such

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policies shall include procedures for conducting criminal background checks, a Colorado Adult Protection Services (CAPS) check, and reference checks prior to employing staff or contractors providing supports and services, and mitigation procedures to be used if the provider agency becomes aware of information that indicates a staff member or volunteer could pose a risk to the health, safety, and welfare of the members served.

b. Provider agencies shall have written policies and procedures to establish qualifications for employees and contractors. Such policies shall include:
    i. Responsibilities assigned to each job description.
    ii. Procedures for initial and continuing training of staff to ensure all duties and responsibilities are accomplished in a competent manner.
    iii. Supervision and management of staff.
    iv. Restrictions prohibiting on-site access to members by staff under the influence of alcohol or illicit drugs that would adversely impact their ability to provide services.

2. Medication Administration
    a. Provider agencies shall establish and maintain policies and procedures for the administration of medication including administration by gastrostomy as part of gastrostomy services described at Section 8.7417
    b. Provider agencies shall establish and maintain written policies and procedures for the appropriate procurement, storage, distribution, and disposal of medications.
        i. All medications shall be stored under proper conditions of temperature and light, and with regard for safety.
        ii. Discontinued and outdated medications, and medication containers with worn, illegible, or missing labels shall be promptly disposed of in a safe manner.
        iii. A record shall be maintained of missing, destroyed, or contaminated medications.
    c. Medication reminder boxes shall used in accordance with Section 25-1.5-303(1), C.R.S.
3. PHI
    a. Provider agencies shall have written policies governing access to duplication and dissemination of information from the member's records in accordance with Section 26-1-114(3), C.R.S. and 42 C.F.R. § 164.502. Within the agency policies for protection of confidentiality, provider agencies shall have written policies and procedures for confidential access to member information by employees as needed to provide the assigned services.
4. Mistreatment, Abuse, Neglect, and Exploitation (MANE)
    a. Pursuant to Section 25.5-10-221, C.R.S., provider agencies shall prohibit MANE of any member.
    b. Provider agencies shall have written policies and procedures for thoroughly investigating cases of alleged or suspected MANE of any member.
    c. MANE policies and procedures shall be consistent with state law and provide a mechanism for monitoring to detect instances of MANE. Monitoring is to include, at a minimum, the review of:
        i. Incident reports;
        ii. Verbal and written reports of unusual or dramatic changes in behavior(s) of members; and,
        iii. Verbal and written reports from members, advocates, families, guardians, and friends of members.

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d. Provider agencies shall establish and maintain procedures for identifying, reporting, reviewing, and investigating all allegations of MANE. Documentation of all investigations shall be maintained. Documentation shall include:
    i. The incident report and preliminary results of the investigation;
    ii. A summary of the investigative procedures utilized;
    iii. The full investigative finding(s); and
    iv. The actions taken.
e. Provider agencies shall
    i. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and contractors who have engaged in MANE.
    ii. Ensure that employees and contractors are made aware of applicable state law and agency policies and procedures related to MANE.
    iii. Require immediate reporting when observed by employees and contractors according to agency policy and procedures and to the agency administrator or his/her designee;
f. Require reporting of allegations within 24 hours to a legally authorized representative and case management agency.

5. Protection of individual rights
    a. All provider agencies shall have written policies and procedures concerning the exercise and protection of individual rights pursuant to Sections 25.5-10-218 through 231, C.R.S. and Sections 8.7001-8.7004.
    b. Provider agencies shall supply members with a Plain Language explanation of their rights.
6. Non-discrimination policies
    a. Provider agencies shall have policies in place that prohibit discrimination on the basis of race, religious or political affiliation, gender, national origin, age, or disability and outline the agency's follow up procedures to address any discriminatory acts.

7. Dispute resolution
    a. Provider agencies shall have procedures for resolution of disputes involving members:
        i. Who were found not eligible or no longer eligible to receive the service(s) from the provider agency;
        ii. Whose services or supports are to be terminated; or,
        iii. Whose services set forth in the Person-Centered Support Plan are to be changed, reduced, or denied.
    b. The procedure shall contain an explanation of the process to be used by members, prospective members, or legally authorized representatives if they are dissatisfied with the decision or action of the provider agency.
    c. The dispute resolution procedures of the provider agency shall, at a minimum, provide the parties the opportunity 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.
    d. Providers shall supply members with a Plain Language explanation of available dispute resolution procedures, along with outside agency contact information, including phone numbers, for assistance.
8. Grievances and complaints

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a. Provider agencies shall have procedures setting forth a process for the timely resolution of grievances or complaints of members, prospective members, or legally authorized representatives, as appropriate. Use of the grievance/complaint procedure shall not prejudice the future provision of appropriate services or supports. No individual shall be coerced, intimidated, threatened, or retaliated against because the individual has exercised his or her right to file a grievance/complaint or participate in the grievance process.

b. The grievance/complaint procedure shall, at a minimum, include:
   i. Identification of the staff member responsible to receive grievances/complaints;
   ii. A mechanism to receive grievances/complaints verbally and/or in writing that requires staff receiving a verbal grievance/complaint to record any verbal grievances and/or complaints;
   iii. Identification of a support person(s) to assist a member to submit a grievance/complaint;
   iv. An opportunity for individuals to meet and attempt to reach a mutually acceptable solution;
   v. Timelines for the resolution of the grievance/complaint;
   vi. Consideration by the agency director or designee if the grievance/complaint cannot be resolved at a lower level; and,

c. Providers shall supply members with a Plain Language explanation of available grievance/complaint procedures, along with outside agency contact information, including phone numbers, for assistance.

d. Providers shall allow grievances/complaints to be submitted anonymously and shall not impose a deadline on the submission of a complaint/grievance.

9. Independent Contractors
   a. Provider agencies may utilize the services of independent contractors at their discretion. If an agency does utilize independent contractors, it shall conduct the vetting, training, and monitoring of, and taking corrective action against contractors.
   b. Nothing in these regulations shall create any contractual relationship between any independent contractor of the provider agency and the Department.
10. Contingency planning
   a. Provider agency shall have a documented contingency plan for providing services if a member's caregiver or direct service provider are unavailable due to an emergency or unforeseen circumstances.
11. Telehealth
   a. Provider agencies that provide HCBS Telehealth services shall establish and maintain documented policies on the use of Telehealth services that comply with Section 8.7559.

8.7410 Personnel

A. Employee records
   1. The provider agency shall maintain records documenting the qualifications and training of employees and contractors who provide services to members.
   2. Provider agencies shall maintain a personnel record for each employee or contractor. The record shall contain:
      a. Documentation of employee/contractor qualifications.
      b. Documentation of training completed.

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c. Documentation of supervision and performance evaluation.
d. Documentation that the employee/contractor was informed of all policies and procedures required by Section 8.7409.
e. Documentation of the employee's/contractor's job description.
f. Documentation of a criminal background check and a CAPs check.

B. License/certification

1. The provider agency shall meet the enrollment requirements for each service it provides prior to providing services. The agency shall ensure each employee or independent contractor maintains the necessary and appropriate license and/or certification to render services. The provider agency shall maintain documentation of current and valid license(s) and certification(s) in the personnel record.

C. Medication administration

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

D. Trainings

1. Provider agencies 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. Training shall be provided prior to employees or contractors having unsupervised contact with members. The training program shall, at a minimum, provide for and include:

    a. Training related to person-centered practices, the role of the Person-Centered Support Plan, and the concept of dignity of risk;
    b. Training related to health, safety, and services and supports to be provided related to the specific needs and diagnoses of members served;
    c. Training specific to the individual(s) for whom the employees or contractors will be providing services and supports which includes medical or behavioral protocols, supervision, dietary and Activities of Daily Living (ADL) needs; and
    d. Provider agencies' internal policies and procedures.

E. Colorado Adult Protective Services (CAPS) and Criminal Background Checks

1. Provider agencies shall conduct criminal background checks and reference checks, and compare the employee's/independent contractor's name against the list of all currently excluded individuals maintained by the Office of Inspector General prior to employing staff or independent contractors to provide services and supports to members. All costs related to obtaining a criminal background check shall be borne by the provider. Background checks shall be completed every five years for each employee and contractor who provides direct care to members.

2. Provider agencies shall comply with the CAPS check requirements set forth at §26-3.1-111(6)(a), C.R.S. and 12 CCR 2518-1, § 30.960.G-J. The agency shall maintain accurate records and make records available to the Department upon request.
    a. HCPF or its designee shall act as the oversight agency described at 26-3.1-111(6)(a)(III) and shall receive CAPS check results
    b. For provider agencies requiring certification, the prospective agency shall:

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i. Submit to the CDPHE a copy of the CAPS check results as part of their initial application for certification.
   a) Substantiated findings as outlined in section 8.7410 E.2.b may result in the denial of the Medicaid enrollment application.

c. Direct care workers with any of the following are prohibited from providing direct care to any member:
   i. An allegation of MANE or harmful act, as defined in Section 26-3.1-101, C.R.S., substantiated by Adult Protection Services (APS) within the last 10 years, at a severity level of "Moderate" or "Severe" as defined in 12 CCR 2518-1; Section 30.100;
   ii. Three or more allegations of MANE or harmful act, as defined in Section 26-3.1-101, C.R.S., substantiated by APS within the last five years, at the minor severity level as defined in 12 CCR 2518; Section 30.100; or
   iii. A criminal conviction of MANE against an at-risk adult defined at 26-3.1-101, C.R.S.
   iv. Only substantiated allegations for which the state level appeal process as defined as 12 CCR 2518-1; Section 30.920 has concluded shall be included in the above exclusions list.

8.7411 Rendering services according to the Person-Centered Support Plan

A. Provider agencies shall maintain on file copies of the current Person-Centered Support Plan for all members they serve. Staff providing direct care to members shall have access to or a copy of the support plan and shall render services as required in the support plan.
B. Provider agencies shall render services according to the agreed upon Person-Centered Support Plan and coordinate with other provider agencies, when applicable. Members receiving services shall be included in developing the Person-Centered Support Plan and have the freedom to choose a willing provider agency.
C. A provider agency shall not condition a member's receipt of any service on the member's agreement to receive other services from the provider.
D. A provider agency shall not discontinue or refuse to provide agreed upon services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.7412 Incident Reporting

A. Provider agencies shall complete the timely reporting, recording, and reviewing of incidents which shall include, but not be limited to:
   1. Death of member receiving services;
   2. Hospitalization of member receiving services;
   3. Medical emergencies, above and beyond first aid, involving member receiving services;
   4. Allegations of MANE;
   5. Injury to member or illness of member;
   6. Damage or theft of member's personal property;
   7. Errors in medication administration;
   8. Lost or missing person receiving services;
   9. Criminal activity;
   10. Incidents or reports of actions by member receiving services that are unusual and require review; and
   11. Use of a rights modification.

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B. A provider shall submit a verbal or written report of every incident to the HCBS member's Case Management Agency (CMA) case manager within 24 hours of discovery of the actual or alleged incident. The report shall include:
   1. Name of person reporting;
   2. Name of member who was involved in the incident;
   3. Member's Medicaid identification number;
   4. Name of persons involved or witnessing the incident;
   5. Incident type;
   6. Date, time, and duration of incident;
   7. Location of incident;
   8. Persons involved;
   9. Description of incident;
   10. Description of action taken;
   11. Whether the incident was observed directly or reported to the provider;
   12. Name of person notified;
   13. Follow-up action taken or where to find documentation of further follow-up;
   14. Name of the person responsible for follow up; and
   15. Resolution, if applicable.

C. If any of the above information is not available and reported to the CMA case manager within 24 hours of the incident, the provider agency must submit follow up information as soon as it is obtained.

D. Additional follow up information may also be requested by the case manager, or the Department. A provider agency is required to submit all follow up information within the timeframe specified by the requesting entity.

E. Case management agencies and providers 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.

F. Provider agencies shall provide victim support for any allegations of MANE.

8.7413 Environmental Standards for provider-owned or -controlled settings

A. Provider-owned or -controlled settings defined at Sections 8.7002.L and M and the provider agencies that own or control them shall comply with all the environmental standards outlined below, in addition to the requirements set forth in Section 8.7003.
   1. The service agency shall conduct fire drills at least quarterly at each physical facility.
   2. All physical facilities shall have working smoke detectors installed and fire extinguishers that have not expired in easily accessible locations that comply with 8 C.C.R. § 1507-101:3.
   3. All physical facilities shall have first aid supplies available.
   4. All service agencies shall comply with the Americans with Disabilities Act (ADA) requirements for accessibility of physical facilities.

B. Physical facilities shall meet all applicable fire, building, licensing, and health regulations.

8.7414 Room and Board

A. Effective January 1 of each year, the Department shall establish a uniform room and board payment for all Medicaid members receiving residential HCBS in or through:
   1. Alternative Care Facility
   2. Supportive Living Program
   3. Transitional Living Program
   4. Individual Residential Service and Supports
   5. Group Residential Service and Supports

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6. Children's Habilitation Residential Program Out-of-Home residential settings

B. The standard room and board amount may not exceed an amount equal to the monthly benefit for Supplemental Security Income (SSI), less an amount specified by the Department for personal needs.

C. Provider agencies shall not charge a Medicaid member more than the Department's annually established room and board rate. The room and board rate shall include all food and meals, basic furniture such as a bed, dresser, and nightstand, linens, utilities, and basic toiletries to include toilet paper, soap, tissues, shampoo, toothpaste, and toothbrush.

8.7415 Medication Administration

A. Provider agencies shall provide sufficient support to members in the use of prescription and non-prescription medications. Members shall be presumed capable of self-administration unless they are determined, through a Level of Care Screen, to need assistance. The type and level of medication administration support provided shall be determined by the results of the Level of Care Screen. Medications shall be administered only by persons authorized in accordance with 6 CCR 1011-1, Chapter VII and XXIV.

1. No prescription medication shall be administered without a written order by a medically licensed provider. Medications/prescriptions shall be reviewed by a physician annually, or more frequently if recommended by the physician or required by law.
2. The provider agency shall ensure that a member's refusal to take medication(s) and/or any adverse reaction to a medication are recorded in the member's medication administration record and reported to the member's physician.
3. For members receiving assistance with medication administration, the physician's order shall be maintained in the member's record.
4. Qualified medication administration personnel shall record all medications administered, including the date, time and amount of each medication administered.

A. For members who are independent in the administration of medications and who do not require monitoring each time medication is taken, the provider agency shall review of medications quarterly to determine that medications are taken correctly.

B. The Provider Agency shall apply the Rights Modification requirements and process at 8.7003.D for any member whose assessment shows they need assistance with medication administration but decline the assistance.

8.7416 Psychotropic Medications

A. Psychotropic medication for members shall be used only for diagnosed psychiatric disorders and:

1. When prescribed by a physician following a psychiatric evaluation;
2. When the person's Person-Centered Support Plan specifies the use of psychotropic medication, and a comprehensive review of the person's life situation and Person-Centered Support Plan has been completed. The Person-Centered 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;
3. After informed consent of the member or legally authorized representative has been obtained, or pursuant to a valid court order; and
4. If the member is enrolled in a waiver that requires establishment of a Human Rights Committee, after review by the committee.

B. Administration of psychotropic medications to a member receiving residential services and supports shall:

1. Be as directed in a time-limited prescription of no more than 90 days written by an authorized medical professional or psychologist and reviewed at least annually by a physician;
2. Be administered per prescriber's orders;

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\major revision\	{combined/moved similar language}
~~[outdated reference (removed)]~~	[outdated reference (to be updated) – language to be removed]-ALSO CURRENT REGULATIONS INTEGRATED INTO NEW SECTION
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3. Include regular monitoring of the member for side effects;
4. Include documentation of the effects of medications and any changes in medication; and,
5. Not be ordered on a PRN or "as needed" basis.

C. The Provider Agency shall ensure all employees and contractors are aware of and document potential side effects and adverse reactions to psychotropic medications.

8.7417 Gastrostomy Services for Developmental Disabilities (DD) and Supported Living Services (SLS) Waivers

A. Gastrostomy services means assistance with the ingestion of food or administration of medication through gastrostomy tubes, naso-gastric tubes or jejunostomy tubes.

B. Licensed Group Residential Service and Supports (GRSS) settings shall comply with all applicable regulations at 6 C.C.R. 1011-1; Chapter VIII, Section 17 for the administration of gastrostomy services.

C. Gastrostomy services shall not be administered by an unlicensed individual unless that individual is trained and supervised by a licensed physician, nurse, or other practitioner. The licensed nurse, physician or other practitioner overseeing the initial and periodic training shall document in the record of such individuals:
1. The date or dates on which the training occurred;
2. Documentation confirming that, in the opinion of such licensed nurse, physician, or other practitioner, the unlicensed individual has reached proficiency in performing all aspects of the individualized protocol referred to in section 8.7417.E.1; and,
3. The legible signature and title of such licensed nurse, physician, or other practitioner.

D. A licensed nurse, physician or other authorized health care practitioner shall monitor each unlicensed person performing the gastrostomy services for a member on a quarterly basis during the first year and semi-annually thereafter, unless more frequent monitoring is required by the individualized protocol. The supervising practitioner shall document each instance of monitoring in the record of the member.

E. The provider agency shall ensure that a physician, licensed nurse, or other practitioner has developed a written, individualized gastrostomy service protocol for each member requiring such service, and that the protocol is updated each time the orders change for that member's gastrostomy services.
1. The provider agency shall maintain the individualized protocol in the record of the member. The protocol shall include, at a minimum,:
a. The proper procedures for preparing, storing, and administering gastrostomy services;
b. The proper care and maintenance of the gastrostomy site, needed materials and equipment;
c. The identification of possible problems associated with gastrostomy services; and,
d. 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 8.740015.D.

F. The provider agency shall ensure that a physician, licensed nurse, or other practitioner provides training to any unlicensed individual who may provide gastrostomy services. Documentation of initial and any subsequent training shall be kept in the member's record.

G. The provider agency shall ensure that the physician, licensed nurse, or other practitioner observes and documents the unlicensed individual performing gastrostomy services and documents the monitoring in the record of the member receiving gastrostomy services.

H. For each gastrostomy service received by a member, the provider agency shall ensure the following documentation is included in the member's record:
1. A written record of each nutrient and fluid administered;
2. The beginning and ending time of nutrient or fluid intake;
3. The amount of nutrient or fluid intake;

Key (ctrl-f bracket type to find relevant revision):

\major revision\	{combined/moved similar language}
~~[outdated reference (removed)]~~	[outdated reference (to be updated) – language to be removed]-ALSO CURRENT REGULATIONS INTEGRATED INTO NEW SECTION
Areas requiring further review	

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.

8.7418 Organized Health Care Delivery System

A. The OHCDS is the Medicaid provider of record for a member whose services are delivered through the OHCDS and shall ensure contracted providers are qualified and provide appropriate and approved services.
B. As the OHCDS, the CMA shall purchase approved goods and services, as specified by the Department, when willing and qualified service providers are not available in the CMA's defined service area. The CMA shall act as the OHCDS for the following services:
    1. Assistive Technology
    2. Hippotherapy
    3. Specialized Medical Equipment and Supplies
    4. Vehicle Modification
    5. Vision
    6. Recreational equipment/fees/passes
    7. Primary Caregiver Education
C. The CMA shall enroll with the Department for the corresponding provider specialties and shall submit claims for reimbursement based on approved PARs for the cost of the good or service.
D. The CMA shall verify that subcontractors and vendors meet and continue to meet all provider credentialing requirements, as outlined in the provider enrollment information.
E. The CMA shall have a purchase agreement with the vendor(s) used for the purchase of goods and services, to include but not limited to devices, recreational equipment and passes, and medical equipment and supplies.
F. The CMA shall document attempts to find two bids where possible for vehicle modifications.
G. The CMA shall ensure the purchase of goods is done at a fair market value.
H. The CMA establish processes and procedures to mitigate conflict of interest or personal gain by a case manager when purchasing goods or services for the services outlined above.
I. The CMA shall not submit claims for reimbursement for the services described in this section 8.7418.

8.7419 Telehealth (8.615)

A. Provider agencies that choose to use HCBS Telehealth shall comply with all regulations at Section 8.7559.