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8.7500 Provider Agency Requirements

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8.7501 Statement of Purpose and Scope

A. The purpose of this Section XXX is to outline requirements for provider agencies that render HCBS to eligible members. These rules apply to all HCBS under all authorities.

8.7502 Definitions

A. Authorized Representative means an individual designated by a member, or by the parent or guardian of the member receiving services, if appropriate, to assist the member receiving services in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) or In-Home Support Services (IHSS).

B. Case Manager shall be as defined in Section 8.7101.

C. Case Management Agency (CMA) shall be as defined in Section 8.7101.

D. Certification means a determination made by the Department, after considering a recommendation from the state survey agency, that a Provider Agency is in compliance with applicable Department statutes, rules, and program requirements for specific Home and Community Based Services.

E. Critical Incident shall be as defined in Section 8.7201.

F. Department shall be as defined in Section 8.7201.

G. Developmental Disability has the same meaning set forth in CRS 25.5-6-403(3.3)(a) and waiver rules [XXXX].

H. Guardian means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem S, as set forth in Section 15-14-102 (4), C.R.S.

I. Health First Colorado means the public health insurance for Coloradans who qualify. Medicaid is funded jointly by the federal government and Colorado state government and is administered by the Department of Health Care Policy & Financing.

J. Home and Community Based Services Waiver means a state and federal program for Medicaid beneficiaries to receive long-term service and supports in their own home or community rather than institutions or other isolated settings.

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K. Medicaid member means any person enrolled in the Health First Colorado and eligible to receive services.

L. Medicaid means Health First Colorado, the state's Medicaid program.

M. 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.

N. Prior Authorization Request means approval for an item or service that is obtained in advance either from the department, the operating agency, a state fiscal agent or the case management agency.

O. Personal Health Information (PHI) means any protected health information, including, without limitation any information whether oral or recorded in any form or medium: (i) 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 (ii) that identifies the individual or with respect to which there is a 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 by the federal Health Insurance Portability and Accountability Act.

P. Provider Agency means an agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at [XXX].

Q. Provider Participation Agreement means the agreement entered into between the Department and the Provider, and that the Provider has electronically consented to or accepted the terms of the agreement.

R. Provider Specialty means a grouping of services a qualifying, and authorized, HCBS provider may deliver and be reimbursed for upon enrollment by the Department's Fiscal Agent. Reimbursement for HCBS services predicated on member eligibility and a provider's inclusion in the member's service plan."

S. Subcontractor means an individual that performs work on behalf of a provider agency but is not an employee of the agency.

T. Telehealth means the broad use of technologies to provide approved services and supports through HCBS waivers when the Member is in a different location from the provider.

U. Waiver Service means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.7503 \Enrollment Standards

A. Provider agencies must:

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

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2. Abide by all the terms of their Provider Participation Agreement with the Department; and
3. Comply with all federal and state statutory and regulatory requirements. This includes, but is not limited to, compliance with 10 CCR 2505-10, [Sections 8.125; 8.126; 8.130]; and regulations pertaining to the specific services rendered by the provider agency.

8.7504 Provider Certification, Decertification and Termination

A. Certification
   1. Prior to enrolling to provide, providing, or billing for services that require certification, provider agencies shall obtain such certification.
   2. A provider agency seeking certification as an HCBS provider, shall submit a written request to the Department or its agent.
   3. Upon receipt of the written 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.
   7. Provider agencies must 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 must 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 under 42 C.F.R 455.106; or change in Geographical Service Area.

B. Change in Information
   1. Provider agencies must notify the Department within 35 calendar days of the loss or termination of certification and/or licensure that is required for Home and Community Based Services provider enrollment in accordance with [Section 8.130.45]. The notification must be submitted through the Provider Portal as a maintenance application to end-date the specialty or disenrollment request.

C. Decertification
   1. A Provider may lose one or more of its certifications and will no longer be able to bill for goods or services authorized by the certification or certifications if any of the following occur:
      a. The Provider fails to comply with any federal or state statute, rules, or guidance.
      b. The Provider fails to comply with any requests by the Department or its agents.
      c. The Provider is no longer eligible to provide the services allowed under the certification.
      d. The Provider poses a threat to the health, safety, or welfare of Medicaid members.
      e. The Provider will be sent written notice thirty (30) calendar days prior to the decertification, unless otherwise required by federal or state statute, regulation, or guidance.
         i. The notice will detail the reason for the decertification.

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ii. The notice will give the Provider the opportunity to dispute the decertification.

f. 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. Within five (5) business days of the decertification, the Provider shall receive notice.

g. If the Provider 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.

h. The Department will review the request and issue a determination on the decertification which will include the Provider's right to file an appeal in accordance with Section 8.050.

i. The effective date of the inactivation may be backdated to the date of the occurrence described above.

D. Termination of Provider Agreements [(8.487.70)]

1. The Department shall initiate termination of a provider agreement pursuant to [Section 8.076.]

8.7505 Change of Ownership

A. Provider agencies that possess certification and/or licensure from the Department of Public Health and Environment must complete the CDPHE Change of Ownership (CHOW) process concurrent to the initiation of the CHOW process with the Department and its Fiscal Agent.

B. A Change of Ownership resulting in a change of Federal Employer Identification Number (EIN) terminates the Provider Participation Agreement. The new owners must re-apply with the new EIN, submitting a new enrollment application through the Provider Enrollment Portal that includes the selling provider's information and a new Provider Participation Agreement. The change of ownership enrollment application cannot be processed for approval until the selling provider completes and submits a voluntary disenrollment request through the Provider Web Portal.

1. The new owner shall not automatically become a Medicaid provider without meeting licensing, certification, and approval process standards.

8.7506 Documentation

A. All provider agencies must document services rendered and retain records, pursuant to Section 8.130.

B. Documentation of the services provided must 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. Exact nature of the specific tasks performed and documentation of any changes in the member's condition or needs and action taken as a result of the changes; and
5. Units of service provided.
6. For per-diem services, documentation of services rendered must include:
7. Medication Administration Record (MAR) if applicable;
8. Daily attendance tracker;
9. Weekly notes at minimum should include:
    a. Activities member participated in;
    b. Appointments if applicable; and
    c. Respite services or overnight stays elsewhere if applicable

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8.7507 Insurance Requirements [(8.603.8, 8.487.14)]

A. Provider agencies must maintain liability insurance in an amount sufficient to cover total bodily injury or property damage arising from a single incident.
B. Provider agencies managing personal needs funds shall purchase and maintain a surety bond in an amount specified by the Department or provide an irrevocable letter of credit in the same amount, made payable to the state, to protect the personal needs of the member.
C. Provider agencies rendering reimbursable Non-Medical Transportation (NMT) services must 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 that utilize their personal vehicle on behalf of a provider agency to provide reimbursable NMT must maintain the following minimum automobile insurance limits, in addition to the insurance maintained by the provider agency:
    1. Bodily injury (BI) $25/$50K per person/per accident; and
    2. Property damage $15,000.

8.7508 HCBS Provider Billing ((8.487.200 and 8.603.5.M language included below), 8.130.60, 8.040, 8.043 are sections that may need to be referenced)

A. Payment to an enrolled Medicaid service provider will be made only if services are provided to an eligible member and claims are submitted in accordance with the following procedures:
    1. Provider agencies shall verify member eligibility prior to delivering services;
    2. Provider agencies shall verify a Prior Authorization Request (PAR) has been approved for the services in question to be provided to the eligible member 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 10 CCR 2505-10 8.043 and 8.040;
    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. Claims shall be filled out completely and correctly; and
    7. Payment shall not exceed Department established limits as indicated on the rates/fee schedule as published by the Department.
B. Provider agencies shall not collect copayments or seek reimbursement from eligible members for services, when those services are reimbursable through HCBS waivers and/or Health First Colorado.
    1. Services provided in conjunction with HCBS waiver reimbursable services and/or Health First Colorado reimbursable services that are not themselves reimbursable by any Medicaid program, may be billed to the member.
C. Provider agencies or the service provider's designated claim submitting entity shall attend the Department's billing training annually or by request of the Department.

8.7509 Policies and Procedures

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A. Provider agencies must have 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, retaining, and terminating employees and contractors.
      b. Provider agencies shall establish qualifications for employees and contractors.
   2. Medication Administration
      a. Provider agencies must have policies and procedures on the administration of medication, including gastrostomy services.
      b. Provider agencies must have written policies and procedures for the appropriate procurement, storage, distribution, and disposal of medications.
         i. All drugs shall be stored under proper conditions of temperature and light, and with regard for safety.
         ii. Discontinued drugs, outdated drugs, and drug 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. The use of medication reminder boxes shall be pursuant to section 25-1.5-303(1) C.R.S.
   3. Protected Health Information
      a. Provider agencies shall have written policies governing access to duplication and dissemination of information from the member's records in accordance with C.R.S. Section 26-1-114, as amended. Provider agencies shall have written policies and procedures for providing employees with member information needed to provide the services assigned, within the agency policies for protection of confidentiality.
   4. Mistreatment, Abuse, Neglect, and Exploitation [(8.608.8)]
      a. Pursuant to Section 25.5-10-221, C.R.S., provider agencies shall prohibit abuse, mistreatment, neglect, or exploitation of any member.
      b. Provider agencies shall have written policies and procedures for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any member. These policies and procedures must be consistent with state law and:
      c. Provide a mechanism for monitoring to detect instances of abuse, mistreatment, neglect, or exploitation. 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.
      d. Provide procedures for reporting, reviewing, and investigating all allegations of abuse, mistreatment, neglect, or exploitation;
      e. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and contractors who have engaged in abuse, mistreatment, neglect, or exploitation;
      f. Ensure that employees and contractors are made aware of applicable state law and agency policies and procedures related to abuse, mistreatment, neglect or exploitation;

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g. Require immediate reporting when observed by employees and contractors according to agency policy and procedures and to the agency administrator or his/her designee;
h. Require reporting of allegations within 24 hours to a Legally Authorized Representative and case management agency; and
i. Provide necessary victim support.

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 Title 25.5, Article 10, C.R.S. and 10 CCR 2505-10 8.484.
   b. Such policies and procedures shall, at minimum, ensure protection of the individual rights set forth in Section 8.484, subject to the Rights Modification process in Section 8.484.5.
   c. Providers shall supply members with a Plain Language explanation of their rights.
6. Dispute resolution
   a. Provider agencies shall have procedures for resolution of disputes involving individuals:
      i. Who were found not eligible or are no longer eligible for services or supports;
      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 in the event that 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, afford due process by providing for:
      i. The opportunity of the parties to present information and evidence in support of their positions to an impartial decision maker. The impartial decision maker may be the director of the agency taking the action or their designee. The impartial decision maker shall not have been directly involved in the specific decision at issue.
   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.
7. Non-discrimination policies 8.600.5.E
   a. Provider agencies shall have policies in place that prohibit discrimination and outline the agency's follow up procedures to address any discriminatory acts.
8. Grievances and complaints
   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 procedure shall not prejudice the future provision of appropriate services or supports.
   b. The grievance procedure shall, at a minimum, include the following:
      i. Who within the agency will receive grievances;
      ii. That they will have a mechanism to receive them verbally and/or in writing and will have a staff record any verbal grievances and/or complaints;

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iii. Identification of support person(s) to assist in the submission of a grievance;
iv. An opportunity for individuals to come together in order to attempt finding a mutually acceptable solution;
v. Timelines for the resolution of the grievance;
vi. Consideration by the agency director or designee if the grievance cannot be resolved at a lower level; and,
vii. No individual shall be coerced, intimidated, threatened or retaliated against because the individual has exercised his or her right to file a grievance or has participated in the grievance process.

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 must allow grievances/complaints to be submitted anonymously and at any time (not subject to a deadline).

9. Subcontracting
   a. Provider agencies may utilize the services of subcontractors at their discretion. If an agency does utilize subcontractors, it is responsible for vetting, training, monitoring, and taking corrective action with subcontractors.
   b. Nothing in these regulations shall create any contractual relationship between any subcontractor of the provider agency and the Department.
10. Contingency planning 8.519.11.B.2.iv
   a. Provider agency shall have procedures in place that identifies a contingency plan for how necessary support will be provided in the event that a member's caregiver, or direct service provider is unavailable due to an emergency situation or unforeseen circumstances.
11. Telehealth
   a. Provider agencies that provide HCBS Telehealth shall have a policy as described at ____ above.

8.75010 Personnel

A. Employee records
   1. The provider agency shall maintain records documenting the qualifications and training of employees and contractors who provide services pursuant to these rules and regulations.
   2. Provider agencies shall maintain a personnel record for each employee or contractor. The record shall contain at least the following:
      a. Documentation of employee/contractor qualifications.
      b. Documentation of training.
      c. Documentation of supervision and performance evaluation.
      d. Documentation that the employee/contractor was informed of all policies and procedures required by these rules.
      e. A copy of the employee's/contractor's job description.

B. License/certification
   1. The provider agency must meet the enrollment requirements for each service it provides. This includes the responsibility for ensuring each employee or subcontractor maintains the

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necessary and appropriate license and/or certification to render services. The provider agency is responsible for maintaining records with current and valid license(s) and certification(s).

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 systems shall have passed a competency evaluation offered by an approved training entity, as defined in 6 CCR 1011-1, Chapter 24, et seq.

D. Trainings
   1. Provider agencies shall have an organized program of orientation and training of sufficient scope for employees and subcontractors to carry out their duties and responsibilities efficiently, effectively and competently. The training program shall, at a minimum, provide for and include the following:
      a. Training to be provided prior to employees or subcontractors having unsupervised contact with members;
      b. Training related to person-centered practices, the role of the Person-Centered Support Plan, and the concept of dignity of risk;
      c. Training related to health, safety, and services and supports to be provided and related to the specific needs and diagnoses of
      d. members served;
      e. Training specific to the individual(s) for whom the employees or subcontractors will be providing services and supports; and
      f. Provider agencies' programmatic policies and procedures.

E. CAPS/BGC
   1. Provider agencies may conduct background checks and reference checks prior to employing staff or subcontractors providing support and services to members. A provider shall not employ any person convicted of an offense that could pose a risk to the health, safety, and welfare of members. All costs related to obtaining a criminal background check shall be borne by the provider.
   2. Provider agencies must comply with the Colorado Adult Protection Services (CAPS) requirements, outlined in §26-3.1-111, C.R.S. and 12 CCR 2518-1, Volume 30.960. The agency must maintain accurate records and make records available to the Department upon request.
      a. Direct service provider means any person providing direct services and supports, including case management services, protective services, physical care, mental health services, or any other service necessary for the at-risk adult's health, safety, or welfare, pursuant to C.R.S. 26-3.1-101 (3.5). Direct service providers include provider agency applicants and owners, as they are ultimately responsible for the members they serve.
      b. During the enrollment process the provider agency may be granted provisional approval to render Medicaid services. Final agency approval is contingent on submission of documentation of a completed CAPS check on the agency applicant and owner within 90 days from the receipt of the provisional approval.
         i. Failure to submit the required documentation within 90 days of the provisional approval period may result in rescindment of the provisional approval.

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ii. For the purposes of C.R.S. 26-3.1-111 (6)(a)(III), the Department of Health Care Policy and Financing is the oversight agency for provider agencies and must be informed of CAPS check results for employers who run them on themselves.

c. Direct Service and backup providers with any of the following are prohibited from providing direct care to any member:

i. An allegation of abuse, neglect, exploitation, 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 abuse, neglect, exploitation, 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 abuse, neglect, or exploitation against an at-risk adult with Intellectual and Developmental Disabilities (IDD) as defined in Section 18-6.5-102, C.R.S.

iv. Only substantiated allegations that have exhausted the appeal period and come to a final disposition, as defined as 12 CCR 2518-1 Section 30.920, shall be included in the above exclusions list.

8.75011 Rendering services according to the Person-Centered Support Plan [(8.602.4.A)]

A. Provider agencies shall maintain on file copies of the current Person-Centered Support Plan for all members they serve.

B. Provider agencies must render services according to the 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 the provider agency that best meets their needs.

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 services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.75012 Critical Incident Reporting [(8.608.6, 8.487.15, 8.49.4.F, 8.495.6.C)]

A. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a member. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a member. Critical Incidents include, but are not limited to:

1. Death;
2. Abuse/neglect/exploitation;
3. Serious injury to member or illness of member;
4. Damage or theft of member's property;
5. Medication mismanagement;
6. Lost or missing person; and
7. Criminal activity.

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B. A provider must 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 must include:
   1. Member name;
   2. Member Medicaid identification number;
   3. Waiver;
   4. Incident type;
   5. Date and time of incident;
   6. Location of incident;
   7. Persons involved;
   8. Description of incident; and
   9. Resolution, if applicable.

C. If any of the above information is not available within 24 hours of the incident and not reported to the CMA case manager, a follow-up to the initial report must be completed.

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 24 hours from the time it was requested.

8.75013 Environmental Standards for provider-owned or -controlled settings

A. Provider-owned or -controlled settings are defined at [8.484.2.J and 8.484.2.K]. These settings and the provider agencies that own or control them must comply with all of the environmental standards outlined below, in addition to the requirements set forth in [8.484].
   1. The physical facilities shall be inspected by the local fire authority prior to occupancy and at least once every three years thereafter. The local fire authority shall be informed of the purpose of the facility and potential mobility or ambulation needs of individuals served. If the purpose of the facility changes in a way that impacts the individuals to be served in that facility, then the service agency shall be responsible for informing the local fire authority to determine if another inspection is required.
   2. The service agency shall conduct fire drills at least quarterly at each physical facility.
   3. All physical facilities shall have smoke detectors and fire extinguishers.
   4. All physical facilities shall have first-aid supplies available.
   5. All service agencies shall comply with the Americans with Disabilities Act (ADA) with regard to physical facilities.

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

8.75014 Room and Board [(8.495.7.A, 8.603.5.K)]

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

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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 but is not limited to: basic furniture such as a bed, dresser, and nightstand, linens, utilities, and basic toiletries to include: toilet paper, soap, tissues, shampoo, toothpaste, and toothbrush.

8.75015 Medication Administration

A. Provider agencies shall provide sufficient support to members in the use of prescription and non-prescription medications to protect the health and safety of members. Decisions concerning the type and level of support provided shall be based on the abilities and needs of the members as determined by assessment and shall be in compliance with these rules. All medications shall be administered only by persons as authorized by law.
   1. No prescription medication shall be administered without a written order by a licensed physician or dentist. The drug regimen of each member who takes prescription medication shall be reviewed and evaluated by a licensed physician no less often than annually and more frequently if recommended by the physician or required by law.
   2. Refusals to take medications by a member and drug reactions shall be recorded. On-going refusals to take medications shall be addressed by the person's physician.
   3. For members who are not independent in the administration of their own medications the following shall be required:
      a. A written record of medications, including time and the amount of medication, taken by the member; and,
      b. Physician orders for over the counter medications.
   4. For members who are independent in the administration of medications and who do not require monitoring each time medication is taken, the service agency shall provide sufficient, at minimum quarterly, monitoring or review of medications to determine that medications are taken correctly.
   5. Provider assistance with medication administration is a Rights Modification if the individual indicates that they would prefer to handle such tasks on their own.

B. Psychotropic Medications
   1. Psychotropic medication for members and supports shall be used only for diagnosed psychiatric disorders and:
      i. When a specific psychiatric evaluation or consultation has resulted in the recommendation for use of medication;
      ii. 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;
      iii. After informed consent of the member or Legally Authorized Representative has been obtained, or pursuant to a valid court order; and
      iv. When reviewed by the Human Rights Committee (HRC), if the member is participating in a waiver for which HRC review is applicable.

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	

C. Administration of psychotropic medications to a member receiving residential services and supports shall:
   1. Be authorized through a time-limited prescription of no more than ninety (90) days by a fully licensed medical professional or psychologist and reviewed at least annually by a physician;
   2. Be administered per prescriber's orders;
   3. Ensure employees and contractors are knowledgeable of potential side effects and adverse reactions to the drugs;
   4. Include regular monitoring of the member for side effects;
   5. Include documentation of the effects of medications and any changes in medication; and,
   6. Not be ordered on a PRN or "as needed" basis.

D. Gastrostomy Services
   1. Gastrostomy services is the ingestion of food or administration of medication through gastrostomy tubes or naso-gastric tubes.
   2. Licensed Group Residential Service and Supports (GRSS) settings must comply with all applicable regulations at 6 CCR 1011-1 Chapter VIII, Section 17 for the administration of gastrostomy services.
   3. 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.
   4. 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.
   5. 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.
   6. 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 said monitoring in the record of the member receiving gastrostomy services.

8.75016 Organized Health Care Delivery System

A. 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 and is responsible for ensuring contracted providers are qualified and provide appropriate and approved services.

B. As the OHCDS, Case Management Agencies (CMA) will be responsible for the purchase of specified goods and services, as specified by the Department, when willing and qualified service providers are not available in the CMA's designated service area. The CMA may will act as the OHCDS for the following services:
   1. Assistive Technology
   2. Specialized Medical Equipment and Supplies
   3. Vehicle Modification
   4. Vision
   5. Recreational equipment/fees/passes
   6. Hippotherapy

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	

C. The CMA must enroll with the Department for the corresponding provider specialties and will submit claims for reimbursement based on approved prior authorization requests.
D. The CMA will verify that subcontractors and vendors meet and continue to meet all provider credentialing requirements, as outlined in the provider enrollment information.
E. The CMA must 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 must document attempts to find two bids where possible for vehicle modifications.
G. The CMA must ensure the purchase of goods is done at a fair market value.
H. The CMA must put in place 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 may not apply fees to any claim for the services listed above.

8.75017 Telehealth (8.615)

A. Provider agencies that choose to use HCBS Telehealth must comply with all regulations at\ [10 CCR 2505-10 XXX].