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DRAFT
2nd Set of Services I-Y
8.7500 HCBS Benefits and Services Rule Revisions

8.7527 In Home Services and Support (IHSS)

IHSS Eligibility

A. In Home Services and Supports (IHSS) is a service available to members enrolled in one of the following HCBS waivers:
   1. Children's Home and Community-Based Services Waiver
   2. Complementary and Integrative Health Waiver
   3. Elderly, Blind, Disabled Waiver

IHSS Definitions

A. ~~[Assessment means a comprehensive evaluation with the member seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the member's medical provider to determine the member's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department prescribed tool to complete assessments.]~~
B. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS. A family member, including a spouse, may be an Attendant.
C. Authorized Representative means an individual designated by the member, or by the parent or guardian of the member, if appropriate, who has the judgment and ability to assist the member in acquiring and receiving services under Title 25.5, Article 6, Part 12, C.R.S. The authorized representative shall not be the eligible person's service provider.
D. Care Plan means a written plan of care developed between the member or the member's Authorized Representative, IHSS Agency and Case Management Agency that is authorized by the Case Manager.
E. ~~[Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6-106, C.R.S., and has a current provider participation agreement with the Department.~~
F. ~~Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual member's functional eligibility for the Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the member, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such member's needs.]~~
G. Extraordinary Care means a service that~~which~~ exceeds the range of care a family member would ordinarily perform in a household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the member and avoid institutionalization.
H. ~~Family member means any person related to the member by blood, marriage, adoption, or common law as determined by a court of law.~~
I. ~~[Health Maintenance Activities means those routine and repetitive skilled health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if they were physically able, or that would be carried out by Family members or friends if they were available. These activities include skilled tasks typically performed by a Certified Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment and judgement of a licensed nurse.~~
J. ~~Homemaker Services means general household activities provided by an Attendant in the member's primary living space to maintain a healthy and safe home environment for a member,~~

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~~when the person ordinarily responsible for these activities is absent or unable to manage these tasks.]~~

K. Inappropriate Behavior means documented verbal, sexual or physical threats or abuse committed by the member or Authorized Representative toward Attendants, Case Managers, or the IHSS Agency.

L. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of institutions. These services include but are not limited to: information and referral services, independent living skills training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and institutions to home and community-based living, or upon leaving secondary education.

M. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the member or member's Authorized Representative, including Health Maintenance Activities and support for activities of daily living or instrumental activities of daily living, Personal Care services and Homemaker services.

N. In-Home Support Services (IHSS) Agency means an agency that is certified by the Colorado Department of Public Health and Environment, enrolled in the Medicaid program and provides Independent Living Core Services.

O. Licensed Health Care Professional means a state-licensed Registered Nurse (RN) who contracts with or is employed by the IHSS Agency.

P. Licensed Medical Professional means the primary care provider of the member, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN) as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

Q. ~~[Personal Care means services which are furnished to an eligible member meet the member's physical, maintenance and supportive needs, when those services are not skilled Personal Care, do not require the supervision of a nurse, and do not require physician's orders.~~

R. ~~Prior Authorization Request (PAR) means the Department prescribed process used to authorize HCBS waiver services before they are provided to the member, pursuant to Section 8.485.90.]~~

IHSS Member Eligibility

A. To be eligible for IHSS the member shall meet the following eligibility criteria:

1. Be enrolled in a Medicaid program approved to offer IHSS.
2. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition stating that the member has sound judgment and the ability to self-direct care. If the member is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.
3. Members who elect or are required to have an Authorized Representative must appoint an Authorized Representative who has the judgment and ability to assist the member in acquiring and using services.
4. Demonstrate a current need for covered Attendant support services.

B. IHSS eligibility for a member will end if:

1. The member is no longer enrolled in a Medicaid program approved to offer IHSS.
2. The member's medical condition deteriorates causing an unsafe situation for the member or the Attendant as determined by the member's Licensed Medical Professional.
3. The member refuses to designate an Authorized Representative ~~[or receive assistance from an IHSS Agency]~~ when the member is unable to direct their own care as documented by the member's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.
4. The member provides false information or false records.
5. The member no longer demonstrates a current need for Attendant support services.

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IHSS Inclusions and Covered Services

C. Services are for the benefit of the member. Services for the benefit of other persons are not reimbursable.

D. Services available for eligible adults (as defined in EBD and CIH waivers):
   1. Homemaker
   2. Personal Care
   3. Health Maintenance Activities

E. Services available for eligible children (as defined in the CHCBS waiver):
   1. Health Maintenance Activities

F. Service Inclusions:
   1. Homemaker:
      a. {Refer to Homemaker at 8.7526}
      b. ~~[Routine housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas;~~
      c. ~~Meal preparation;~~
      d. ~~Dishwashing;~~
      e. ~~Bed making;~~
      f. ~~Laundry;~~
      g. ~~Shopping for necessary items to meet basic household needs.]~~
   2. Personal Care:
      a. {Refer to Personal Care at 8.7536}
      b. ~~[Eating/feeding which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;~~
      c. ~~Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask to or from the member's face;~~
      d. ~~Preventative skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays and/or solutions, and monitoring for skin changes.~~
      e. ~~Bladder/Bowel Care:~~
         i. ~~Assisting member to and from the bathroom;~~
         ii. ~~Assistance with bed pans, urinals, and commodes;~~
         iii. ~~Changing incontinence clothing or pads;~~
         iv. ~~Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;~~
         v. ~~Emptying ostomy bags;~~
         vi. ~~Perineal care.~~
      f. ~~Personal hygiene:~~
         i. ~~Bathing including washing, shampooing;~~
         ii. ~~Grooming;~~
         iii. ~~Shaving with an electric or safety razor;~~
         iv. ~~Combing and styling hair;~~
         v. ~~Filing and soaking nails;~~
         vi. ~~Basic oral hygiene and denture care.~~
      g. ~~Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints, and the application of artificial limbs when the member is able to assist or direct.~~
      h. ~~Transferring a member when the member has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the member and Attendant are fully trained in the use of the equipment and the member can direct and assist with the transfer.~~
      i. ~~Mobility assistance when the member has the ability to reliably balance and bear weight or when the member is independent with an assistive device.~~

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j. ~~Positioning when the member is able to verbally or non-verbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.~~
k. ~~Medication Reminders when medications have been preselected by the member, a Family member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:~~
   i. ~~Medication minders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;~~
   ii. ~~Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the member and opening the appropriately marked medication minder if the member is unable to do so independently.~~
l. ~~Cleaning and basic maintenance of durable medical equipment.~~
m. ~~Protective oversight when the member requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property.~~
n. ~~Accompanying includes going with the member, as indicated on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the member may include providing one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the attendant.]~~

3. Health Maintenance Activities:
   a. {Refer to Health Maintenance (Self-Directed) Activities at 8.7522}
   b. ~~[Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection, and the member is unable to apply prescription creams, lotions, or sprays independently due to illness, injury or disability. Skin care may include wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when directed by a Licensed Medical Professional.~~
   c. ~~Hair care including shampooing, conditioning, drying, and combing when performed in conjunction with health maintenance level bathing, dressing, or skin care. Hair care may be performed when:~~
      i. ~~The member is unable to complete task independently;~~
      ii. ~~Application of a prescribed shampoo/conditioner which has been dispensed by a pharmacy; or~~
      iii. ~~The member has open wound(s) or neck stoma(s).~~
   d. ~~Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing and trimming.~~
   e. ~~Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:~~
      i. ~~There is injury or disease of the face, mouth, head or neck;~~
      ii. ~~In the presence of communicable disease;~~
      iii. ~~When the member is unable to participate in the task;~~
      iv. ~~Oral suctioning is required;~~
      v. ~~There is decreased oral sensitivity or hypersensitivity;~~
      vi. ~~member is at risk for choking and aspiration.~~
   f. ~~Shaving performed when health maintenance level skin care is required in conjunction with the shaving, or:~~
      i. ~~The member has a medical condition involving peripheral circulatory problems;~~
      ii. ~~The member has a medical condition involving loss of sensation;~~
      iii. ~~The member has an illness or takes medications that are associated with a high risk for bleeding;~~

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iv. ~~The member has broken skin at/near shaving site or a chronic active skin condition.~~

g. ~~Dressing performed when health maintenance level skincare or transfers are required in conjunction with the dressing, or;~~
   i. ~~The member is unable to assist or direct care;~~
   ii. ~~Assistance with the application of prescribed anti-embolic or pressure stockings is required;~~
   iii. ~~Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.~~

h. ~~Feeding is considered a health maintenance task when the member requires health maintenance level skin care or dressing in conjunction with the task, or:~~
   i. ~~Oral suctioning is needed on a stand-by or intermittent basis;~~
   ii. ~~The member is on a prescribed modified texture diet;~~
   iii. ~~The member has a physiological or neurogenic chewing or swallowing problem;~~
   iv. ~~Syringe feeding or feeding using adaptive utensils is required;~~
   v. ~~Oral feeding when the member is unable to communicate verbally, non-verbally or through other means.~~

i. ~~Exercise including passive range of motion. Exercises must be specific to the member's documented medical condition and require hands-on assistance to complete.~~

j. ~~Transferring a member when they are not able to perform transfers due to illness, injury or disability, or:~~
   i. ~~The member lacks the strength and stability to stand, maintain balance or bear weight reliably;~~
   ii. ~~The member has not been deemed independent with adaptive equipment or assistive devices by a Licensed Medical Professional;~~
   iii. ~~The use of a mechanical lift is needed.~~

k. ~~Bowel care performed when health maintenance level skin care or transfers are required in conjunction with the bowel care, or:~~
   i. ~~The member is unable to assist or direct care;~~
   ii. ~~Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;~~
   iii. ~~Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.~~

l. ~~Bladder care performed when health maintenance level skin care or transfers are required in conjunction with bladder care, or;~~
   i. ~~The member is unable to assist or direct care;~~
   ii. ~~Care of external, indwelling and suprapubic catheters;~~
   iii. ~~Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.~~

m. ~~Medical management as directed by a Licensed Medical Professional to routinely monitor a documented health condition, including but not limited to: blood pressures, pulses, respiratory rate, blood sugars, oxygen saturations, intravenous or intramuscular injections~~

n. ~~Respiratory care:~~
   i. ~~Postural drainage~~
   ii. ~~Cupping~~
   iii. ~~Adjusting oxygen flow within established parameters~~
   iv. ~~Suctioning of mouth and nose~~
   v. ~~Nebulizers~~
   vi. ~~Ventilator and tracheostomy care~~
   vii. ~~Assistance with set-up and use of respiratory equipment~~

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o. ~~Bathing is considered a health maintenance task when the member requires health maintenance level skin care, transfers or dressing in conjunction with bathing.~~

p. ~~Medication Assistance, which may include setup, handling and assisting the member with the administration of medications. The IHSS Agency's Licensed Health Care Professional must validate Attendant skills for medication administration and ensure that the completion of task does not require clinical judgement or assessment skills.~~

q. ~~Accompanying includes going with the member, as necessary on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the member also may include providing one or more health maintenance tasks as needed during the trip. Attendant may assist with communication, documentation, verbal prompting and/or hands on assistance when the task cannot be completed without the support of the Attendant.~~

r. ~~Mobility assistance is considered a health maintenance task when health maintenance level transfers are required in conjunction with the mobility assistance, or:~~

~~i. The member is unable to assist or direct care;~~

~~ii. When hands-on assistance is required for safe ambulation and the member is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or~~

~~iii. The member has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional.~~

s. ~~Positioning includes moving the member from the starting position to a new position while maintaining proper body alignment, support to a member's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;~~

~~i. The member is unable to assist or direct care, or~~

~~ii. The member is unable to complete task independently.]~~

IHSS Exclusions and Limitations

A. {HCBS Elderly, Blind, and Disabled (EBD), Complementary Integrative Health (CIH), and Children's Home and Community Based Services (CHCBS) Waivers:

1. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and PAR must be submitted and approved by the case manager and received by the IHSS Agency prior to services being rendered. Services rendered in advance of approval and receipt of these documents are not reimbursable.
2. Services rendered by an Attendant who shares living space with the member or Family members are reimbursable only when there is a determination by the Case Manager, made prior to the services being rendered, that the services meet the definition of Extraordinary Care.
3. Health Maintenance Activities may include related Personal Care and/or Homemaker services if such tasks are completed in conjunction with the Health Maintenance Activity and are secondary or contiguous to the Health Maintenance Activity.
   a. Secondary means in support of the main task(s). Secondary tasks must be routine and regularly performed in conjunction with a Health Maintenance Activity. There must be documented evidence that the secondary task is necessary for the health and safety of the member. Secondary tasks do not add units to the care plan.
   b. Contiguous means before, during or after the main task(s). Contiguous tasks must be completed before, during, or after the Health Maintenance Activity. There must be documented evidence that the contiguous task is necessary for

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the health and safety of the member. Contiguous tasks do not add units to the care plan.

c. The IHSS Agency shall not submit claims for Health Maintenance Activities when only Personal Care and/or Homemaking services are completed.

4. Independent Living Core Services, attendant training, and oversight or supervision provided by the IHSS Agencies Licensed Health Care Professional are not separately reimbursable. No additional compensation is allowable for IHSS Agencies for providing these services.
5. Travel time shall not be reimbursed.
6. Companionship is not a benefit of IHSS and shall not be reimbursed.

B. HCBS Children's Home and Community Based (CHCBS) Waiver:
1. IHSS for CHCBS shall be limited to tasks defined as Health Maintenance Activities.
2. Family members of a member can only be reimbursed for extraordinary care.

C. HCBS Elderly, Blind, and Disabled (EBD), Complementary Integrative Health (CIH) Waivers:
1. Family members shall not be reimbursed for more than forty (40) hours of Personal Care services in a seven (7) day period.
2. Restrictions on allowable Personal Care units shall not apply to parents who provide Attendant services to their eligible adult children under In-Home Support Services as set forth at Section 8.7536.04.4.c.i.5.} ~~[8.485.204.D]~~

IHSS Member and Authorized Representative Participation and Self-Direction

A. A member or their Authorized Representative may self-direct the following aspects of service delivery:
1. Present a person(s) of their own choosing to the IHSS Agency as a potential Attendant. The member must have adequate Attendants to assure compliance with all tasks in the Care Plan.
2. Train Attendant(s) to meet their needs.
3. Dismiss Attendants who are not meeting their needs.
4. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.
5. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the member's Licensed Medical Professional.
6. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.
7. Communicate with the IHSS Agency and case manager to ensure safe, accurate and effective delivery of services.
8. Request a reassessment, as described at {Section 8.7206.6.B} [~~Section 8.393.2.D~~], if level of care or service needs have changed.

B. An Authorized Representative is not allowed to be reimbursed for IHSS Attendant services for the member they represent.

C. If the member is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:
1. Must be at least 18 years of age.
2. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.

D. The Authorized Representative must attest to the above requirement on the Shared Responsibilities Form.

E. IHSS members who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS member.

F. The member and their Authorized Representative must adhere to IHSS Agency policies and procedures.

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IHSS Agency Eligibility

G. The IHSS Agency must be a licensed home care agency. The IHSS Agency shall be in compliance with all requirements of their certification and licensure, in addition to requirements outlined at ~~[Section 8.487].~~8.7400.

H. Administrators or managers as defined at 6 CCR 1011-1 Chapter 26 shall satisfactorily complete the Department authorized training on IHSS rules and regulations prior to Medicaid certification and annually thereafter. \Providers must upload the certificate of completion annually into the Medicaid Provider Portal.\

IHSS Agency Responsibilities

A. The IHSS Agency shall assure and document that all members are provided the following:
   1. Independent Living Core Services
      a. An IHSS Agency must provide a list of the full scope of Independent Living Core Services provided by the agency to each member on an annual basis. The IHSS Agency must keep a record of each member's choice to utilize or refuse these services, and document services provided.
   2. Attendant training, oversight and supervision by a licensed healthcare professional.
   3. The IHSS agency shall provide 24-hour back-up service for scheduled visits to members at any time an Attendant is not available. At the time the Care Plan is developed the IHSS Agency shall ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.

B. The IHSS Agency shall adhere to the following:
   1. If the IHSS Agency admits members with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the agency or have other effective back-up plans to ensure the needs of the member are met.
   2. The IHSS Agency shall only accept members for care or services based on a reasonable assurance that the needs of the member can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.
      a. There shall be documentation in the Care Plan or member record of the agreed upon days and times of services to be provided based upon the member's needs that is updated at least annually.
   3. If an IHSS Agency receives a referral of a member who requires care or services that are not available at the time of referral, the IHSS Agency shall advise the member or their Authorized Representative and the case manager of that fact.
      a. The IHSS Agency shall only admit the member if the member or their Authorized Representative and case manager agree the recommended services can be delayed or discontinued.
   4. The IHSS Agency shall ensure orientation is provided to members or Authorized Representatives who are new to IHSS or request re-orientation through the Department's prescribed process. Orientation shall include instruction in the philosophy, policies, and procedures of IHSS and information concerning member rights and responsibilities.
   5. The IHSS Agency will keep written service notes documenting the services provided at each visit.

C. The IHSS Agency is the legal employer of a member's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by the Department.

D. The IHSS Agency shall assist all members in interviewing and selecting an Attendant when requested and maintain documentation of the IHSS Agency's assistance and/or the member's refusal of such assistance.

E. The IHSS Agency will complete an intake assessment following referral from the case manager. \Utilizing the authorized units provided on the IHSS Care Plan Calculator provided by the case manager,\ the IHSS Agency will develop a Care Plan in coordination with the case manager and

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member. Any proposed services outlined in the Care Plan that \differ from the\ ~~[may result in an increase in]~~ authorized services and units must be submitted to the case manager for review. The Care Plan must be approved prior to the start of services.

F. The IHSS Agency shall ensure that a current Care Plan is in the member's record, and that Care Plans are updated with the member at least annually or more frequently in the event of a member's change in condition. The IHSS Agency will send the Care Plan to the case manager for review and approval.
    1. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope and duration of each service to be provided to the member for each day and visit. The Care Plan shall be signed by the member or the member's Authorized Representative and the IHSS Agency.
        a. Secondary or contiguous tasks must be outlined on the care plan as described in Section {8.7527.05.3.a-b} [~~Section 8.552.8.F~~].
    2. In the event of the observation of new symptoms or worsening condition that may impair the member's ability to direct their care, the IHSS Agency, in consultation with the member or their Authorized Representative and case manager, shall contact the member's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the member's revised Care Plan, with the member and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the case manager for review and approval.

G. The IHSS Agencies Licensed Health Care Professional is responsible for the following activities:
    1. Administer a skills validation test for Attendants who will perform Health Maintenance Activities. Skills validation for all assigned tasks must be completed prior to service delivery unless postponed by the member or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS Agency in the member's file. In no event shall the skills validation be postponed for more than thirty (30) days after services begin to prevent interruption in services.
    2. Verify and document Attendant skills and competency to perform IHSS and basic member safety procedures.
    3. Counsel Attendants and staff on difficult cases and potentially dangerous situations.
    4. Consult with the member, Authorized Representative or Attendant in the event a medical issue arises.
    5. Investigate complaints and incidents within ten (10) calendar days as defined in {Section 8.740~~1~~12}.
    6. Verify the Attendant follows all tasks set forth in the Care Plan.
    7. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the member, their Authorized Representative, or the case manager.
    8. Provide in-home supervision for the member as recommended by their Licensed Medical Professional and as agreed upon by the member or their Authorized Representative.

H. At the time of enrollment and following any change of condition, the IHSS Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the member record.
    1. The IHSS Agency shall collaborate with the member or member's Authorized Representative to determine the level of supervision provided by the IHSS Agency's Licensed Health Care Professional beyond the requirements set forth at Section 25.5-6-1203, C.R.S.
    2. The member may decline recommendations by the Licensed Medical Professional for in-home supervision. The IHSS Agency must document this choice in the member record and notify the case manager. The IHSS Agency and their Licensed Health Care Professional, case manager, and member or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

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I. The IHSS Agency shall assure and document that all Attendants have received training in the delivery of IHSS prior to the start of services. Attendant training shall include:
   1. Development of interpersonal skills focused on addressing the needs of persons with disabilities.
   2. Overview of IHSS as a service-delivery option of consumer direction.
   3. Instruction on basic first aid administration.
   4. Instruction on safety and emergency procedures.
   5. Instruction on infection control techniques, including universal precautions.
   6. Mandatory reporting and incident reporting procedures.
   7. Skills validation test for unskilled tasks assigned on the care plan.

J. The IHSS Agency shall allow the member or Authorized Representative to provide individualized Attendant training that is specific to their own needs and preferences.

K. With the support of the IHSS Agency, Attendants must adhere to the following:
   1. Must be at least 18 years of age and demonstrate competency in caring for the member to the satisfaction of the member or Authorized Representative.
   2. May be a family member subject to the reimbursement and service limitations in {8.7527.10.}
   3. Must be able to perform the assigned tasks on the Care Plan.
   4. Shall not, in exercising their duties as an IHSS Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse as defined in Section 25.5-6-1203, C.R.S.
   5. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.

L. The IHSS Agency shall provide functional skills training to assist members and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

IHSS Case Management Agency Responsibilities

A. The case manager shall provide information and resources about IHSS to eligible members, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.

B. The case manager will initiate a referral to the IHSS Agency of the member or Authorized Representative's choice, including an outline of approved services as determined by the case manager's most recent assessment. The referral must include the Physician Attestation, assessment information, and other pertinent documentation to support the development of the Care Plan.

C. The case manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:
   1. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.
   2. The Shared Responsibilities Form shall be completed upon enrollment and following any change of condition. If the member requires an Authorized Representative, the Shared Responsibilities Form must include the designation and attestation of an Authorized Representative.

D. Upon the receipt of the Care Plan, the case manager shall:
   1. Review the Care Plan within five business days of receipt to ensure there is no disruption or delay in the start of services.
   2. Ensure all required information is in the member's Care Plan and that services are appropriate given the member's medical or functional condition. If needed, request additional information from the member, their Authorized Representative, the IHSS Agency, or Licensed Medical Professional regarding services requested.

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3. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.
4. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the member's eligible benefits.
5. Collaborate with the member or their Authorized Representative and the IHSS Agency to establish a start date for services. The case manager shall discontinue any services that are duplicative with IHSS.
6. Authorize cost-effective and non-duplicative services via the Prior Authorization Request (PAR). Provide a copy of the PAR to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.
7. Work collaboratively with the IHSS Agency, member, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.
    a. Case managers will complete the {Long-Term Care Waiver Program Notice of Action} [~~Notice Services Status~~] (LTC-803) and provide the member or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the member's rights to fair hearing, and appeal procedures.

E. The case manager shall ensure cost-effectiveness and non-duplication of services by:
1. Documenting the discontinuation of previously authorized agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by IHSS.
2. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.
    a. A member may receive non-duplicative services from multiple Attendants or agencies if appropriate for the member's level of care and documented service needs.
3. Ensuring the member's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan and requesting additional information as needed.
4. Coordinating transitions from a hospital, nursing facility, or other agency to IHSS. Assisting members with transitions from IHSS to alternate services if appropriate.
5. Collaborating with the member or their Authorized Representative and the IHSS Agency in the event of any change in condition. The case manager shall request an updated Physician Attestation of Consumer Capacity form. The case manager may revise the Care Plan as appropriate given the member's condition and functioning.
6. Completing a reassessment if requested by the member as described at {Section 8.7206.6.A.2}, if level of care or service needs have changed.

F. The case manager shall not authorize more than one consumer-directed program on the member's PAR.

G. The case manager shall participate in training and consultative opportunities with the Department's Consumer-Directed Training & Operations contractor.

H. Additional requirements for case managers:
1. Contact the member or Authorized Representative once a month during the first three months of receiving IHSS to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.
2. Contact the member or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.

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3. Contact the member or Authorized Representative when a change in Authorized Representative occurs and continue contact once a month for three months after the change takes place.
4. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the agency, and supervision provided. The case manager must document and keep record of the following:
    a. IHSS Care Plans;
    b. In-home supervision needs as recommended by the Physician;
    c. Independent Living Core Services offered and provided by the IHSS Agency; and
    d. Additional supports provided to the member by the IHSS Agency.

I. Start of Services

1. Services may begin only after the requirements defined at {8.7527.3, 8.7527.8.E, 8.7527.8.I, and 8.7527.9.C of this rule} [~~Sections 8.552.2, 8.552.6.E., 8.552.6.I., and 8.552.7.C.~~] have been met.
2. [The case manager shall follow the Department's utilization management review process and receive authorization prior to authorizing a start date for Attendant services for support plans that;
    a. Contain Health Maintenance Activities; or
    b. Exceed the cost of care received in an institutional setting]
3. ~~\Care Plans that exceed the cost of care in an institutional setting cannot be authorized by the Case Manager without Department approval. The Case Manager will follow the Department's over-cost containment process and receive authorization prior to authorizing a start date for Attendant services.\~~
4. ~~\Care Plans that include Health Maintenance Activities cannot be authorized by the case manager without Department approval. The case manager will follow the Department's utilization management review process and receive authorization prior to authorizing a start date for Attendant services.\~~
5. ~~[Department review for cost containment as defined at~~ Sections 8.486.80 and 8.506.12 ~~must be completed prior to issuance of the PAR to the IHSS Agency.]~~
6. The Case Manager shall establish a service period and submit a PAR, providing a copy to the IHSS Agency prior to the start of services.

IHSS Reimbursement and Service Limitations

A. IHSS Personal Care services must comply with the rules for reimbursement set forth at Section {8.7536 (Personal Care)}. IHSS Homemaker services must comply with the rules for reimbursement set forth at Section {8.7526 (Homemaker)}.
B. The IHSS Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved PAR. The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.
C. The IHSS Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.
D. Services by an Authorized Representative to represent the member are not reimbursable. IHSS services performed by an Authorized Representative for the member that they represent are not reimbursable.
E. An IHSS Agency shall not be reimbursed for more than twenty-four hours of IHSS service in one day by an Attendant for one or more members collectively.
F. A member cannot receive IHSS and Consumer Directed Attendant Support Services (CDASS) at the same time.

IHSS Discontinuation and Termination

A. A member may elect to discontinue IHSS or use an alternate service-delivery option at any time.

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B. A member may be discontinued from IHSS when equivalent care in the community has been secured.

C. The case manager may terminate a member's participation in IHSS for the following reasons:

1. The member or their Authorized Representative fails to comply with IHSS program requirements as defined in Section {8.7527.06} [~~8.552.4~~], or
2. A member no longer meets program criteria, or
3. The member provides false information, false records, or is convicted of fraud, or
4. The member or their Authorized Representative exhibits Inappropriate Behavior, and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.
    a. The IHSS Agency and case manager are required to assist the member or their Authorized Representative to resolve the Inappropriate Behavior, which may include the addition of or a change of Authorized Representative. All attempts to resolve the Inappropriate Behavior must be documented prior to notice of termination.

D. When an IHSS Agency discontinues services, the agency shall give the member and the member's Authorized Representative written notice of at least thirty days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice shall be considered given when it is documented that the member or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the case manager agency.

1. Exceptions will be made to the requirement for advanced notice when the IHSS Agency has documented that there is an immediate threat to the member, IHSS Agency, or Attendants.
2. Upon IHSS Agency discretion, the agency may allow the member or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

E. If continued services are needed with another agency, the current IHSS Agency shall collaborate with the case manager and member or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the member's safety and welfare.

F. In the event of discontinuation or termination from IHSS, the case manager shall:

1. Complete the {Long-Term Care Waiver Program Notice of Action} [~~Notice Services Status~~] (LTC-803) and provide the member or the Authorized Representative with the reasons for termination, information about the member's rights to fair hearing, and appeal procedures. Once notice has been given, the member or Authorized Representative may contact the case manager for assistance in obtaining other home care services or additional benefits if needed.

~~[CHCBS: 8.506.4.C~~
~~8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552~~
~~8.506.4.C In Home Support Services:~~
~~1. IHSS for CHCBS s shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.~~
~~2. Family members of a can only be reimbursed for extraordinary care.]~~

8.7528 Independent Living Skills Training

8.7528.01 Independent Living Skills Training Eligibility

A. Independent Living Skills Training is a service available to members enrolled in the HCBS Brain Injury Waiver.

8.7528.02 Independent Living Skills Training Descriptions and Definitions

B. Independent Living Skills Training (ILST) means services designed {and developed on the} ~~and directed at the development and maintenance of the program~~ member's ability to independently

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sustain themselves physically, emotionally, and economically in the community. ILST may be provided in the member's residence or in the community. ~~or in a group living situation~~.

C. ILST person-centered support plans are plans that describe the ILST services necessary to enable the member to independently sustain themselves physically, emotionally, and economically in the community. This plan is developed with the member and the provider.

D. ILST Trainers are individuals trained in accordance with guidelines listed below and tasked with providing the service to the member.

E. The Person-Centered Support Plan is a plan of care created by a process that is driven by the individual and may also include people chosen by the individual, as well as the appropriate health care professional and the designated ILST trainer(s). It provides necessary information and support to the member to ensure that they direct the process to the maximum extent possible. It documents member choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the member needs to function safely in the community. This plan is developed by the member, provider, and case manager.

8.7528.03 Independent Living Skills Training Inclusions

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

1. Self-care, including but not limited to basic personal hygiene;
2. Medication supervision and reminders;
3. Household management;
4. Time management skills training;
5. Safety awareness skill development and training;
6. Task completion skill development and training;
7. Communication skill building;
8. Interpersonal skill development;
9. Socialization, including but not limited to acquiring and developing appropriate social norms, values, and skills;
10. Recreation, including leisure and community integration activities;
11. Sensory motor skill development;
12. Benefits coordination, including activities related to the coordination of Medicaid services;
13. Resource coordination, including activities related to coordination of community transportation, community meetings, neighborhood resources, and other available public and private resources;
14. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting.

B. All Independent Living Skills Training shall be documented in the person-centered support plan. Reimbursement is limited to services described in the person-centered support plan.

8.7528.04 Independent Living Skills Exclusions and Limitations

A. Benefit is not provided for members who reside in a Supportive Living Program (SLP) as defined in Section {8.7547} [~~8.515.85~~].

B. Travel to and from the member's home is not reimbursable.

8.7528.05 Independent Living Skills Training Provider Agency Requirements

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

1. Agencies seeking to provide ILST services must have a valid Home Care Agency Class A or B license or an Assisted Living Residency license and Transitional Living Program certification from the Department of Public Health and Environment.
2. Agencies must employ an ILST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, brain injury, and a degree within a relevant field.
    a. This coordinator must review ILST person-centered support plans to ensure member plans are designed and directed at the development and maintenance

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of the member's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

3. 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 member. These professionals must hold licenses with no limitations in one of the following professions:
    a. Occupational Therapist;
    b. Physical Therapist;
    c. Registered Nurse;
    d. Speech Language Pathologist;
    e. Psychologist;
    f. Neuropsychologist;
    g. Medical Doctor;
    h. Licensed Clinical Social Worker;
    i. Licensed Professional Counselor.
4. Professionals providing components of the ILST plan may include individuals who are members of agency staff, contracted staff, or external licensed and certified professionals who are fully aware of duties conducted by ILST trainers.
5. All ILST person-centered support plans containing any professional activity must be reviewed and authorized at least every 6 months, or as needed, by professionals responsible for oversight as referenced in {8.7528.05.A.3.a-i.} [~~8.516.10.C.1.c.i ix.~~]

B. ILST trainers must meet one of the following education, experience, or certification requirements:
1. Licensed health care professionals with experience in providing functionally based assessments and skills training for individuals with disabilities; or
2. Individuals with a bachelor's degree and one (1) year of experience working with individuals with disabilities; or
3. Individuals with an associate degree in a social service or human relations area and two (2) years of experience working with individuals with disabilities; or
4. 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 three (3) years of experience providing services similar to ILST services; or
5. Individuals with four (4) years direct care experience teaching or working with individuals with a brain injury or other cognitive disability either in a home setting, hospital setting, or rehabilitation setting.

C. The agency shall administer a series of training programs to all ILST trainers.
1. Prior to delivery of and reimbursement for services, ILST trainers must complete the following trainings:
    a. Person-centered care approaches;
    b. HIPAA and member confidentiality;
    c. Basics of brain injury including at a minimum:
        i. Basic neurophysiology;
        ii. Impact of a brain injury on an individual;
        iii. Epidemiology of brain injury;
        iv. Common physical, behavioral, and cognitive impairments and interactions strategies;
        v. Best practices in brain injury recovery; and
        vi. Screening for a history of brain injury.
    d. On-the-job coaching by an incumbent ILST trainer;
    e. Basic safety and de-escalation techniques;
    f. Training on community and public resource availability;
    g. Understanding of current brain injury recovery guidelines; and
    h. First aid.
2. ILST trainers must also receive ongoing training, required annually, in the following areas:
    a. Cultural awareness;
    b. Updates on brain injury recovery guidelines; and

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c. Updates on resource availability.

8.7528.06 Independent Living Skills Training Provider Reimbursement

A. ILST shall be reimbursed according to the number of units billed, with one (1) unit equal to fifteen (15) minutes of service. Payment and billing may not include travel time to and from the member's residence.

~~[Intensive Supports~~

~~I. CHRP Intensive Support~~

~~This service aligns strategies, interventions, and supports for the member and family, to prevent the need for out of home placement.~~

~~This service may be utilized in maintaining stabilization, preventing crisis situations, and/or de-escalation of a crisis.~~

~~C. \A crisis may be self-identified, family identified, and/or identified by an outside party.\~~

~~CHRP Intensive Support Inclusions:~~

~~A. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the member and their family.~~

~~A crisis is an event, series of events, and/or state of being that is more severe than normal for the child or youth and/or family; is outside the manageable range for the child or youth and/or their caregivers; and poses a danger to self, family, and/or the community.~~

~~Identification of needs for crisis prevention and intervention may include, but are not limited to:~~

~~i. Cause(s) and triggers that could lead to a crisis.~~
~~ii. Physical and behavioral health factors.~~
~~iii. Education services.~~
~~iv. Family dynamics.~~
~~v. Schedules and routines.~~
~~vi. Current or history of police involvement.~~
~~vii. Current or history of medical and behavioral health hospitalizations.~~
~~viii. Current services.~~
~~ix. Adaptive equipment needs.~~
~~x. Past interventions and outcomes.~~
~~xi. Immediate need for resources.~~
~~xii. Respite services.~~
~~xiii. Predictive Risk Factors.~~
~~xiv Increased Risk Factors.]~~

8.7529 Life Skills Training

8.7529.01 Life Skills Training Eligibility

A. Life Skills Training is a service available to members enrolled in one of the following HCBS waivers:
1. Community Mental Health ~~Services~~ Supports Waiver
2. Complementary and Integrative Health Waiver
3. Elderly, Blind, and Disabled Waiver
4. Supported Living Services Waiver

8.7529.02 Life Skills Training Descriptions

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

B. Life Skills Training trainers directly support the member by designing with the member an individualized LST support plan. Trainers implement the plan to develop and maintain the members' ability to independently sustain themselves physically, emotionally, socially and economically in the community.

C. The LST coordinator reviews the member's LST support plan to ensure it is designed to meet the needs of the member in order to enable them to independently sustain themselves physically, emotionally, and economically in the community.

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8.7529.03 Life Skills Training Inclusions

A. HCBS Elderly, Blind, and Disabled (EBD) Waiver; Community Mental Health Supports (CMHS) Waiver; Complementary and Integrative Health (CIH) Waiver; Supported Living Services (SLS) Waiver

B. Life Skills Training includes assessment, training, maintenance, supervision, assistance, or continued supports of the following skills:

1. Problem-solving;
2. Identifying and accessing mental and behavioral health services;
3. Self-care and activities of daily living;
4. Medication reminders and supervision, not including medication administration;
5. Household management;
6. Time management;
7. Safety awareness;
8. Task completion;
9. Communication skill building;
10. Interpersonal skill development;
11. 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;
12. Recreation, including leisure and community engagement;
13. Assistance with understanding and following plans for occupational or sensory skill development;
14. Accessing resources and benefit coordination, including activities related to coordination of community transportation, community meetings, community resources, housing resources, Medicaid services, and other available public and private resources;
15. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting; and
16. Acquiring and utilizing assistive technology when appropriate and not duplicative of training covered under other services.

8.7529.02 Life Skills Training Service Access and Authorization

A. To obtain approval for Life Skills Training, the member must demonstrate a need for the service as follows:

1. The member demonstrates a need for training designed and directed to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community;
2. The member identifies skills for which training is needed and demonstrates that without the skills, the member risks their health, safety, or ability to live in the community;
3. The member demonstrates that without training they could not develop the skills needed; and
4. The member demonstrates that with training they have the ability to acquire these skills or services necessary within 365 days.

B. To establish eligibility for Life Skills Training, the member must satisfy general criteria for accessing the service:

1. The member is transitioning from an institutional setting to a home and community-based setting, or is experiencing a qualifying change in life circumstance that affects a member's stability and endangers their ability to remain in the community;
2. The member demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and
3. The member demonstrates that they need the service to establish community support or resources where they may not otherwise exist.

8.7529.03 Life Skills Training Service Requirements

A. The member's case manager must not authorize Life Skills Training for more than 365 days. The Department, in its sole discretion, may grant an exception based on extraordinary circumstances.

B. The LST coordinator must share the LST support plan with the member' providers of other HCBS services that support or implement any LST services The LST coordinator will seek permission

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from the member prior to sharing the LST program Person-Centered Support Plan, or any portion of it, with other providers; and

C. Any component of the LST support plan that may contain activities outside the scope of the LST trainer's scope of expertise or licensure must be created by the appropriately licensed professional within his/her scope of practice.

D. All LST support plans containing any professional activity must be reviewed and authorized monthly during the service period, or as needed, by professionals responsible for oversight.

E. All LST providers must maintain a LST support plan that includes:
   1. Monthly skills training plans to be developed and documented;
   2. Skills training plans that include goals, goals achieved or failed, and progress made toward accomplishment of continuing goals;
   3. The start and end time/duration of service provision;
   4. The nature and extent of service;
   5. A description of LST activities;
   6. Progress toward support plan goals and objectives; and
   7. The provider's signature and date.

F. The LST support plan shall be sent to the Case Management Agency (CMA) responsible for the support plan on a quarterly basis, or as requested by the CMA.

G. The LST support plan shall be shared, with the member's permission, with the member's providers of other HCBS services.

8.7529.04 Life Skills Training Service Exclusions and Limitations

A. Members may utilize LST up to 24 units (six hours) per day, for no more than 160 units (40 hours) per week, for up to 365 days following the first day the service is provided.

B. LST is not to be delivered simultaneously during the direct provision of 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.
   1. LST services may be provided in conjunction with Non-Medical Transportation if it is outlined in the member's LST support plan. Services are billable only when provided by an enrolled NMT provider, who is not the LST provider.

C. LST does not include services offered through State Plan or other waiver services, except those that are incidental to the LST training activities or purposes or are incidentally provided to ensure the member's health and safety during the provision of LST.

8.7529.05 Life Skills Training Service Provider Agency Requirements

A. The agency must employ an LST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, or a degree within a relevant field; and

B. The agency must ensure any component of the LST plan that may contain activities outside the scope of the LST trainer's expertise or licensure must be created by an appropriately licensed professional acting within his/her scope of practice.
   1. The professional must hold a license with no limitations in the scope of practice appropriate to meet the member's LST needs. The following licensed professionals are authorized to furnish LST training:
      a. Occupational Therapist;
      b. Physical Therapist;
      c. Registered Nurse;
      d. Speech Language Pathologist;
      e. Psychologist;
      f. Neuropsychologist;
      g. Medical Doctor;
      h. Licensed Clinical Social Worker
      i. Licensed Professional Counselor; or
      j. Board Certified Behavior Analyst (BCBA).

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2. An appropriately licensed professional providing a component(s) of the LST plan may be an agency staff member, contract staff member, or external licensed and certified professionals who are fully aware of duties conducted by LST trainers.

C. An agency must maintain a Class A or B Home Care Agency License issued by the Colorado Department of Public Health and Environment if that agency chooses to provide training on Personal Care as defined at {8.7536}.

D. The agency must employ one or more LST Trainers to directly support members, one-on-one, by designing with the member their LST support plan and implementing the plan for the member's training.

1. An individual is qualified to be an LST trainer only if they are:
   a. A licensed healthcare professional with experience in providing functionally based assessments and skills training for individuals with disabilities;
   b. An individual with a bachelor's degree and one (1) year of experience working with individuals with disabilities;
   c. An individual with an associate's degree in a social service or human relations area and two (2) years of experience working with individuals with disabilities;
   d. An individual currently enrolled in a degree program directly related to special education, occupational therapy, therapeutic recreation, and/or teaching with at least three (3) years of experience providing services similar to LST services;
   e. An individual with four (4) years direct care experience teaching or working with needs of individuals with disabilities; or
   f. An individual with four (4) years of lived experience transferable to training designed and directed with the member to develop and maintain his/her ability to sustain himself/herself physically, emotionally, socially and economically in the community. The provider must ensure that this individual receives member-specific training sufficient to enable the individual to competently provide LST to the member consistent with the LST support plan.
      i. ~~For anyone qualifying as a trainer under this criterion, the provider must ensure that the trainer receives additional member specific training sufficient to enable them to competently provide LST to the member's that is consistent with the support plan.~~
2. Prior to delivery of and reimbursement for any services, LST trainers must complete the following trainings:
   a. Person-centered support approaches;
   b. HIPAA and member's confidentiality;
   c. Basics of working with the population to be served;
   d. On-the-job coaching by the provider or an incumbent LST trainer on the provision of LST training;
   e. Basic safety and de-escalation techniques;
   f. Community and public resource availability; and
   g. Recognizing emergencies and knowledge of emergency procedures including basic first aid, home and fire safety.
3. The provider must ensure that staff acting as LST trainers receive ongoing training within 90 days of unsupervised contact with a member, and no less than once annually, in the following areas:
   a. Cultural awareness;
   b. Updates on working with the population to be served; and
   c. Updates on resource availability.

8.7529.06 Life Skills Training Service Provider Agency Reimbursement:

A. LST may be billed in 15-minute units. Members may utilize LST up to 24 units (six hours) per day, no more than 160 units (40 hours) per week, for up to 365 days following the first day the service is provided.

B. Payment for LST shall be the lower of the billed charges or the maximum rate of reimbursement.

C. LST may include escorting members if doing so is incidental to performing an authorized LST service. However, costs for transportation in addition to those for accompaniment may not be billed

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LST services. If accompaniment and transportation are provided through the same agency, the person providing transportation may not be the same person who provided accompaniment as a LST benefit to the member.

8.7530 Massage Therapy

8.7530.01 Massage Therapy Eligibility

A. Massage Therapy is a service available to members enrolled in one of the following HCBS waivers:
   1. Children with Life Limiting Illness
   2. Children's Extensive Support Waiver
   3. Children's Habilitation Residential Program
   4. Complementary and Integrative Health Waiver
   5. Supported Living Services Waiver

8.7530.02 Massage Therapy Definition

A. Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and psychological changes.

8.7530.03 Massage Therapy Inclusions

A. Massage therapy shall only be used for the treatment of conditions related to the member's illness, medical need, or behavioral need {as identified on the person-centered support plan.}
B. Massage therapy includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension, and WATSU.
C. Massage Therapy shall be provided in a licensed massage therapist's office, an approved outpatient setting, or in the member's residence.
D. HCBS Complementary and Integrative Health Waiver (CIH); Support Living Services (SLS)
   1. Members receiving massage therapy services may be asked to participate in an independent evaluation to determine the effectiveness of the services.

8.7530.04 Massage Therapy Exclusions and Limitations

A. Massage therapy is not available if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.
B. HCBS Support Living Services (SLS) Waiver; Children's Extensive Services (CES) Waiver; Children with Life Limiting Illness (CLLI) Waiver; Children's Habilitation Residential Program (CHRP) Waiver:
   1. The following items are excluded and are not eligible for reimbursement:
      a. Acupuncture;
      b. Chiropractic care; and
      c. Experimental treatments or therapies.
C. Massage Therapy Service Limitations:
   1. HCBS Children with Life Limiting Illness Waiver:
      a. Massage Therapy shall be limited to the member's assessed need up to a maximum of 24 hours per annual certification period.
   2. HCBS Complementary and Integrative Health Waiver:
      a. A member shall not receive more than 408 combined units of ~~all Complementary and Integrative Health Services~~ [acupuncture, chiropractic, and massage therapy waiver services] during the support plan year.

8.7530.05 Massage Therapy Provider Agency Requirements

A. Massage Therapists shall be licensed or registered by the Department of Regulatory Agencies, Division of Registrations, as required by the Massage Therapy Practice Act (C.R.S. § 12-235-101, et seq)
B. HCBS Supported Living Services (SLS) Waiver, HCBS Children's Extensive Services (CES) Waiver; Children's Habilitation Residential Program (CHRP) Waiver:
   1. The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.
C. HCBS Complementary and Integrative Health Waiver

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Areas requiring further review	

1. Massage Therapists shall have at least (1) year of experience practicing Massage Therapy at a rate of 520 hours per year; OR (1) year of experience working with individuals with paralysis or other long term physical disabilities.
2. Massage Therapy Providers shall:
    a. Recommend the appropriate modality, amount, scope, and duration of the massage therapy service within the established limits {at Section 8.7530.04.C.2.a.} [~~as listed at 8.517.11.B~~].
    b. Recommend only services that are necessary and appropriate and that {they will provide ~~will be rendered by the recommending massage therapy provider {in a care plan submitted~~ to the member's case manager.}

8.7531 Mentorship

8.7531.01 Mentorship Eligibility

A. Mentorship is a service available to members enrolled in the HCBS Supported Living Services Waiver.

8.7531.02 Mentorship Definition

A. Mentorship means services that are provided to members to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising.

8.7531.03 Mentorship Inclusions

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.
D. Training in child and infant care for members who are parenting children.

8.7531.04 Mentorship Exclusions and Limitations

A. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.
B. Mentorship services are limited to one hundred and ninety-two (192) units (forty-eight (48) hours) per service-plan year. One (1) unit is equal to fifteen (15) minutes of service.

8.7531.05 Mentorship Reimbursement

A. 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.]~~ {a member beyond the one hundred and ninety two (192) units must be pre authorized by the Department.}

8.7532 Movement Therapy

8.7532.01 Movement Therapy Eligibility

A. Movement Therapy is a service available to members enrolled in one of the following HCBS waivers:
    1. Children's Extensive Support Waiver
    2. Children's Habilitation Residential Program
    3. Supported Living Services Waiver

8.7532.02 Movement Therapy Definition

A. Movement Therapy ~~[means]~~ {is the use of} music therapy ~~[or]~~ {and/or} dance {therapy} as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, ~~[or gross motor skills and assists in pain management and cognition]~~ {pain management, cognition, and gross motor skills.}

8.7532.03 Movement Therapy Inclusions

~~[11.Movement therapy includes the use of music therapy and/ or dance therapy as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.~~

~~Movement therapy is provided by a licensed, certified, registered or accredited professional[.] [and the] Intervention is related to an identified medical [or] [and/or] behavioral need[.] [and] Movement therapy can be reimbursed only when:~~

~~The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession;~~

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

\major revision\	{combined/moved similar language}
~~[outdated reference (removed)]~~	[outdated reference (to be updated)]
Areas requiring further review	

~~The intervention is related to an identified medical [or] [and/or] behavioral need; and, The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.]~~

A. Movement Therapy includes the use of music therapy and/or dance therapy when it addresses an assessed need in the person-centered support plan.
B. Support Living Services (SLS) Waiver:
    1. Movement Therapy include~~s~~ a pass to community recreation centers and shall only be used to access movement therapy, massage therapy, and hippotherapy ~~SLS/CES professional~~ services.~~and t~~ The pass must be purchased in the most cost-effective manner including day passes or monthly passes.

8.7532.04 Movement Therapy Exclusions and Limitations

A. Movement Therapy must be recommended or prescribed by a therapist or physician who is an enrolled Medicaid provider. The recommendation must include the medical need to be addressed and expected outcome(s) from the therapy. The recommending therapist or physician must monitor the progress and effectiveness of the movement therapy at least quarterly.
B. Movement therapy is only authorized as a treatment strategy for a specific medical or behavioral need and identified in the member's person-centered support plan.
C. Movement Therapy is not available under the waiver if it is available under the Medicaid State Plan, {Early and Periodic Screening, Diagnostic and Treatment (EPSDT)}, ~~[EPSDT]~~ or from a Third-Party Resource.
D. HCBS Children's Extensive Services (CES) Waiver
    1. The following items are excluded and are not eligible for reimbursement:
        a. Fitness training (personal trainer);
        b. Warm water therapy;
        c. Experimental treatments or therapies; and
        d. Yoga.
E. HCBS Supported Living Services (SLS) Waiver:
    1. The following items are excluded and are not eligible for reimbursement:
        a. Acupuncture;
        b. Chiropractic care;
        c. Fitness trainer;
        d. Equine therapy;
        e. Art therapy;
        f. Warm water therapy;
        g. Experimental treatments or therapies; and
        h. Yoga.

8.7532.05 Movement Therapy Provider Agency Requirements

A. Movement therapy is provided by a licensed, certified, registered or accredited professional{.} ~~[and the]~~ Intervention is related to an identified medical ~~[or]~~ {and/or} behavioral need{.} ~~[and]~~ Movement therapy can be reimbursed only when:
    1. The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession;
    ~~2.~~ The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

8.7533 Non-Medical Transport

8.7533.01 Non-Medical Transportation Eligibility

A. Non-medical Transportation (NMT) is a service available to members enrolled in one of the following HCBS waivers:
    1. Brain Injury Waiver
    2. Community Mental Health Supports Waiver
    3. Complementary and Integrative Health Waiver

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~~[outdated reference (removed)]~~	[outdated reference (to be updated)]
Areas requiring further review	

4. Developmental Disabilities Waiver
5. Elderly, Blind, and Disabled Waiver
6. Supported Living Services Waiver

8.7533.02 Non-Medical Transportation Definition

A. Non-medical Transportation (NMT) services means transportation which enables eligible members to gain physical access to non-medical community services and supports, as required by the Person-Centered Support Plan to prevent institutionalization.

8.7533.03 Non-Medical Transportation Inclusions

A. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Brain Injury (BI) Waiver:
   1. Non-Medical Transportation services shall include, but not be limited to, transportation between the member's home and non-medical services or supports such as Adult Day Centers, shopping, activities that encourage community integration, counseling sessions not covered by State Plan, and other services as required by the care plan to prevent institutionalization.

B. HCBS Developmental Disabilities (DD) Waiver:
   1. Non-Medical Transportation enables members to gain access to Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services.

C. HCBS Supported Living Services (SLS) Waiver:
   1. Non-Medical Transportation enables members to gain access to the community, Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services.

8.7533.04 Exclusions and Limitations

A. HCBS Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Brain Injury (BI) Waiver; HCBS Developmental Disabilities (DD) Waiver; HCBS Supported Living Services (SLS) Waiver:
   1. Non-Medical Transportation services shall not be used to substitute for medical transportation, as defined in Section 8.014.1.
   2. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the Person-Centered Support Plan.
   3. Non-Medical Transportation services shall only be used after the case manager has determined that free transportation is not available to the member.
   4. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. 440.170. Non-emergency medical transportation is a benefit under the Medicaid State Plan, defined at 42 C.F.R. Section 440.170(a)(4).
   5. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Brain Injury (BI) Waiver:
      a. A member is allowed no more than 104 round trip services (208 units), per support plan year, unless otherwise authorized by the Department.
   6. HCBS Developmental Disabilities (DD) Waiver:
      a. A member is allowed no more than 254 round trip services (508 units) to and from Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services, per certification period.
   7. HCBS Supported Living Services (SLS) Waiver:
      a. A member is allowed no more than 254 round trip services (508) units) to and from Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services, per support plan year.
      b. Transportation in addition to Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services is limited to no more than 104 round trip services (208 units), per support plan year and will be reimbursed at Mileage Band 1.

8.7533.05 HCBS Non-Medical Transportation Provider Agency Requirements

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~~[outdated reference (removed)]~~	[outdated reference (to be updated)]
Areas requiring further review	

A. Providers shall maintain all appropriate limits of auto insurance liability as specified in Provider Agency Requirements 8.7407(C-D). Providers shall ensure that each driver rendering NMT meets the following requirements:
   1. Drivers must be 18 years of age or older to render services;
   2. Have at least one year of driving experience;
   3. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history; and
   4. Complete a Colorado or National-based criminal history record check.

B. Drivers shall be disqualified from serving as drivers for any program members for any of the following:
   1. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;
   2. A conviction in the State of Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;
   3. A conviction in the State of Colorado, within the seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);
   4. A conviction in the State of Colorado, within the four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15 of Title 18, C.R.S.;
   5. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D) within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6114;
   6. A conviction in the State of Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;
   7. A conviction in Colorado within the two (2) years preceding the date the criminal history record check is completed of driving under the influence, as defined in § 42-4-1301(1)(f), C.R.S.; driving with excessive alcohol content, as described in §42-4-1301(1)(g), C.R.S;
   8. A conviction within the two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B), 4 C.C.R. 723-6; § 6114 in any other state or in the United States; and
   9. For purposes of 4 C.C.R. 723-6; § 6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sentence.

C. Vehicles used during the provision of NMT must be safe and in good working order. To ensure the safety and proper functioning of the vehicles, vehicles must pass a vehicle safety inspection prior to it being used to render services.
   1. Safety inspections shall include the inspection of items as described in Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6104.
   2. Vehicles must be inspected on a schedule commensurate with their age:
      a. Vehicles manufactured within the last five (5) years: no inspection.
      b. Vehicles manufactured within the last six (6) to ten (10) years: inspected every 24 months.
      c. Vehicles manufactured eleven (11) years or longer: inspected annually.
      d. Vehicles for wheelchair transportation: inspected annually, regardless of the manufacture date of vehicle.
   3. The vehicle inspector must be trained to conduct the inspection and be employed by an automotive repair company authorized to do business in Colorado.

D. Transportation providers who maintain a certificate or permit through the Public Utilities Commission (PUC) are not required to meet the above requirements. PUC certificate and permit holders shall submit a copy of the certification to the Department for verification of provider credentials.

8.7533.06 Non-Medical Transportation Provider Agency Reimbursement

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\major revision\	{combined/moved similar language}
~~[outdated reference (removed)]~~	[outdated reference (to be updated)]
Areas requiring further review	

A. Reimbursement for non-medical transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services.
B. A provider's submitted charges shall not exceed those normally charged to the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities.
C. Provider charges shall not accrue when the recipient is not physically present in the vehicle.
D. Providers shall not bill for services before they are an approved Medicaid provider and may bill only for those NMT services performed by a qualified driver utilizing a qualified vehicle.

8.7534 Palliative/{Supportive Care}

8.7534.01 Palliative/Supportive Care Eligibility

A. Palliative/Supportive Care is a service available to members enrolled in the HCBS Children with Life Limiting Illness Waiver.

8.7534.02 Palliative/Supportive Care Definition

A. Palliative/Supportive Care means a specific program offered by a licensed healthcare facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care is specialized medical care for people with life limiting illnesses. This type of care is focused on providing members with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. {The goal is to improve the quality of life for both the member and the family. Palliative care is appropriate at any age (18 and under for this waiver) and at any stage in a life limiting illness and can be provided together with curative treatment. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of this waiver, Palliative Care includes Care Coordination and Pain and Symptom Management.}

8.7534.03 Palliative/Supportive Care Inclusions

A. Palliative/Supportive Care {may be provided together with curative treatment and} [~~shall not require a nine month terminal prognosis for the member and~~] includes:
    1. Care Coordination
        a. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the member and central coordination of medical and psychological services.
        b. A Care Coordinator will organize an array of services. This approach will enable the member to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital.
        c. Additionally, a key function of the Care Coordinator will be to manage the [~~assume the~~] majority of the responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers critical information that is related to the care and necessary for effective medical management. [~~The activities of the Care Coordinator will allow for a seamless system of care.~~]
        d. Care Coordination does not include {case management agency or case manager responsibilities.} [~~utilization management, that is review and authorization of service requests, level of care determinations, and waiver enrollment, provided by the case manager at the Single Entry Point.~~]
    2. Pain and Symptom Management
        a. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the member's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms.
        b. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

8.7534.04 Palliative/Supportive Care Provider Agency Requirements

A. Individuals providing Palliative/Supportive Care services shall be employed by or working under a formal contract with a qualified Medicaid hospice or home health agency.

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Areas requiring further review	

B. {The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss.}

8.7535 Peer Mentorship

8.7535.01 Peer Mentorship Eligibility

A. Peer Mentorship is a service available to members enrolled in one of the following HCBS waivers:
   1. Brain Injury Waiver
   2. Community Mental Health Supports Waiver
   3. Complementary and Integrative Health Waiver
   4. Developmental Disabilities Waiver
   5. Elderly, Blind, and Disabled Waiver
   6. Supported Living Services Waiver

8.7535.02 Peer Mentorship Definition

A. Peer Mentorship means support provided by peers to promote self-advocacy and encourage community living among members 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.

8.7535.03 Peer Mentorship Inclusions

A. HCBS Elderly, Blind, and Disabled (EBD) Waiver; Community Mental Health Supports (CMHS) Waiver; Complementary and Integrative Health (CIH) Waiver; Brain Injury (BI) Waiver; Supported Living Services (SLS) Waiver, Developmental Disabilities (DD) Waiver:

B. Peer Mentorship means support provided by peers of the member on matters of community living, including:
   1. Problem-solving issues drawing from shared experience.
   2. Goal Setting, self-advocacy, community acclimation and integration techniques.
   3. Assisting with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups and commissions.
   4. Activities that promote interaction with friends and companions of choice.
   5. Teaching and modeling of social skills, communication, group interaction, and collaboration.
   6. Developing community-member relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests.
   7. Assisting the person in acquiring, retaining, and improving self-help, socialization, self-advocacy, and adaptive skills necessary for community living.
   8. 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.
      a. Assisting members to be aware of and engage in community resources.

8.7535.04 Peer Mentorship Service Access and Authorizations

A. To obtain approval for Peer Mentorship, a member must demonstrate:
   1. A need for soft skills, insight, or guidance from a peer;
   2. That without this service he/she may experience a health, safety, or institutional risk; and
   3. There are no other services or resources available to meet the need.

B. To establish eligibility for Peer Mentorship, the member must satisfy general criteria for accessing service:
   1. The member is transitioning from an institutional setting to a home and community-based setting, or is experiencing a qualifying change in life circumstance that affects a member's stability and endangers their ability to remain in the community,
   2. The member demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and
   3. The member demonstrates that they need the service to establish community support or resources where they may not otherwise exist.

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

\major revision\	{combined/moved similar language}
~~[outdated reference (removed)]~~	[outdated reference (to be updated)]
Areas requiring further review	

8.7535.05 Peer Mentorship Exclusions and Limitations

A. Members may utilize Peer Mentorship up to 24 units (six hours) per day, for no more than 160 units (40 hours) per week, for no more than 365-days.
B. Services covered under the State Plan, another waiver service, or by other resources are excluded.
C. Services or activities that are solely diversional or recreational in nature are excluded.
D. Peer Mentorship shall not be provided by a peer who receives programming from the same residential location, day program location, or employment location as the member.

8.7535.06 Peer Mentorship Provider Agency Requirements

A. The provider must ensure services are delivered by a peer mentor staff who:
   1. Has lived experience transferable to support a member with acclimating to community living through providing them member advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the member's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.
   2. Is qualified to furnish the services customized to meet the needs of the member as described in the support plan;
   3. Has completed training from the provider agency consistent with core competencies. Core competencies include:
      a. Understanding boundaries;
      b. Setting and pursuing goals;
      c. Advocacy for Independence Mindset;
      d. Understanding of Disabilities, both visible and non-visible, and how they intersect with identity; and
      e. Person-Centeredness.

8.7535.05 Peer Mentorship Documentation

A. 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 Section 8.7406 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request, including:
   1. Start and end time/duration of services;
   2. Nature and extent of services;
   3. Mode of contact (face-to-face, telephone, other);
   4. Description of peer mentorship activities such as accompanying members to complicated medical appointments or to attend board, advisory and commissions meetings, and support provided interviewing potential providers;
   5. Progress toward support plan goals and objectives; and
   6. Provider's signature and date.

8.7535.06 Peer Mentorship Provider Agency Reimbursement

A. Peer Mentorship services are reimbursed based on the number of units billed, with one (1) unit equal to 15 minutes of service.
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 support plan.

8.7536 {Personal Care}

8.7536.01 Personal Care Eligibility

A. Personal Care is a service available to members enrolled in one of the following HCBS waivers:
   1. Brain Injury Waiver
   2. Community Mental Health Supports Waiver
   3. Complementary and Integrative Health Waiver
   4. Elderly, Blind, and Disabled Waiver
   5. Supported Living Services Waiver

8.7536.02 Personal Care Definition

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

\major revision\	{combined/moved similar language}
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Areas requiring further review	

A. Personal Care means services provided to an eligible member to meet the member's physical, maintenance, and supportive needs through hands-on assistance, supervision and/or cueing. These services do not require a nurse's supervision or physician's orders.

8.7536.03 Personal Care Inclusions

A. Tasks included in Personal Care:

1. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;
2. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask to or from the member's face;
3. Preventative skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays and/or solutions, and monitoring for skin changes.
4. Bladder/Bowel Care:
    a. Assisting member to and from the bathroom;
    b. Assistance with bed pans, urinals, and commodes;
    c. Changing incontinence clothing or pads;
    d. Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;
    e. Emptying ostomy bags; and
    f. Perineal care.
5. Personal hygiene:
    a. Bathing including washing, shampooing;
    b. Grooming;
    c. Shaving with an electric or safety razor;
    d. Combing and styling hair;
    e. Filing and soaking nails; and
    f. Basic oral hygiene and denture care.
6. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints, and the application of artificial limbs when the member is able to assist or direct.
7. Transferring a member when the member has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the member and \Direct Care Worker (DCW)\ ~~[Attendant]~~ are fully trained in the use of the equipment and the member can direct and assist with the transfer.
8. Mobility assistance when the member has the ability to reliably balance and bear weight or when the member is independent with an assistive device.
9. Positioning when the member is able to verbally or nonverbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.
10. Medication Reminders when medications have been preselected by the member, a family member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:
    a. Medication reminders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;
    b. Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the member and opening the appropriately marked medication minder if the member is unable to do so independently.
11. Accompanying includes going with the member, as indicated on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the member may include providing one or more personal care services as needed during the trip. A \DCW\ ~~[attendant]~~ may assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the \DCW\ .

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

\major revision\	{combined/moved similar language}
~~[outdated reference (removed)]~~	[outdated reference (to be updated)]
Areas requiring further review	

12. Homemaking, as described at {8.7526}, may be provided by personal care staff, if provided during the same visit as personal care.
13. \Cleaning and basic maintenance of durable medical equipment.\
14. Protective oversight:
    a. In the HCBS Elderly, Blind, and Disabled (EBD) Waiver; Brain Injury (BI) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver: is allowed when the member requires stand-by assistance with any of the unskilled personal care described in these regulations, or when the member must be supervised at all times to prevent wandering.
    b. For In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS): is allowed when the member requires supervision to prevent or mitigate disability-related behaviors that may result in imminent harm to people or property.
    c. In the HCBS Supported Living Services (SLS) Waiver: is not allowed.
15. Exercise:
    a. In the HCBS Elderly, Blind, and Disabled (EBD) Waiver; Brain Injury (BI) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS); Supported Living Services (SLS) Waiver: is allowed when not prescribed by a ~~nurse or other~~ licensed medical professional and limited to the encouragement of normal bodily movement, as tolerated, on the part of the member.
16. For In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS): is not allowed as a personal care service. ~~[Personal care services as described above may be used to provide respite care for primary care givers, provided that the respite care does not duplicate any care which the primary caregiver may be receiving payment to provide]~~

B. {Supported Living Services (SLS) Waiver:}
    1. \In addition to the inclusions above, personal care provided under the SLS Waiver also includes:\
        a. Assistance with money management,
        b. Assistance with menu planning and grocery shopping, and
        c. Assistance with health-related services including first aide, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental, and therapy appointments, support that may include accompanying members to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.
        d. ~~Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.~~

8.7536.04 Personal Care Exclusions and Limitations

A. HCBS Brain Injury (BI); Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS), Supported Living Services (SLS) Waiver:
    1. Personal care services shall not include any skilled care. These services as defined under [8.7522, ~~sections for skilled services IHSS/CDASS HMA, PDN, LTHH]~~ shall not be provided as personal care services under HCBS, regardless of the level of the training, certification, or supervision of the personal care employee.
    2. The amount of personal care that is prior authorized is only an estimate. The prior authorization} \includes the number of hours a member may need for their care; the member is not required to utilize all hours, however, the hours authorized cannot be exceeded.\ ~~[of a certain number of hours does not create an entitlement on the part of the member or the provider for that exact number of hours.]~~ {All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the

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member's needs.

3. Personal care provider agencies may decline to perform any specific task, if the supervisor or the personal care staff feels uncomfortable about the safety of the member or the personal care staff, regardless of whether the task may be included in the definition above.
4. Family members shall not be reimbursed for providing only homemaker services. Family members must provide relative personal care in accordance with the following:
    a. Family members may be employed by certified personal care agencies to provide personal care services to relatives under the waiver programs subject to the conditions below. ~~For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.~~
    b. The family member shall meet all requirements for employment by a certified personal care agency and shall be employed and supervised by the personal care agency.
    c. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:
        i. The total number of Medicaid personal care units for a member of the client's family shall not exceed the equivalent of 444 hours per support plan year which is equivalent to an average of 1.2164 hours / day (as indicated on the member's Support Plan).
            1. If the support plan year for the waiver is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the member is receiving care by the average hours per day of personal care for a full year (444/365=1.2164).
            2. The maximum number of Medicaid personal care units per support plan year shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision, and all other administrative costs.
            3. The above restrictions on allowable personal care units shall not apply to members who receive personal care through Consumer Directed Attendant Support Services (CDASS), In Home Support Services (IHSS), or who receive Personal Care through the SLS waiver.
        ii. If two or more waiver members reside in the same household, family members may be reimbursed up to the maximum for each member if the services are not duplicative and are appropriate to meet the member's needs.
        iii. When waiver funds are utilized for reimbursement of personal care services provided by the member's family, the home care allowance cannot be used to reimburse the family.
    d. Documentation of services provided must indicate that the provider is a relative.
5. Billing for travel time is prohibited.

8.7536.05 Personal Care Provider Agency Requirements

A. HCBS Brain Injury (BI); Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS); Supported Living Services (SLS) Waiver:
    1. In addition to the training requirements outlined {in 8.7400 (Provider Agency Requirements) and at Section 8.74~~0~~10 (Personnel Requirements}, personal care provider agencies shall assure and document that all personal care staff have received at least twenty hours of training, or have passed a skills validation test, in the provision of unskilled personal care as described above. Training, or skills validation, shall include the areas of

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bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care, medication reminding, homemaking, and protective oversight. Training shall also include instruction in basic first aid, and training in infection control techniques, including universal precautions. Training or skills validation shall be completed prior to service delivery, except for components of training that may be provided in the member's home, in the presence of the supervisor.

2. All employees providing personal care shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of personal care staff, as specified above. Supervision shall include, but not be limited to, the following activities:
    a. Orientation of staff to agency policies and procedures.
    b. Arrangement and documentation of training.
    c. Informing staff of policies concerning advance directives and emergency procedures.
    d. Oversight of scheduling, and notification to members of changes; or close communication with scheduling staff.
    e. Written assignment of duties on a member-specific basis.
    f. Meetings and conferences with staff as necessary.
    g. Supervisory visits to member's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, member-specific or procedure-specific training of staff, observation of member's condition and care, and assessment of member's satisfaction with services. At least one of the assigned personal care staff must be present at supervisory visits at least once every three months.
    h. Investigation of complaints and incidents.
    i. Counseling with staff on difficult cases, and potentially dangerous situations.
    j. Communication with the case managers, the physician, and other providers on the care plan, as necessary to assure appropriate and effective care.
    k. Oversight of record keeping by staff.
3. A personal care agency may be denied or terminated from participation in Colorado Medicaid, according {to 8.7404}. Additionally, personal care agencies may be terminated for the following:
    a. Improper Billing Practices:
        i. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the member's home. Providers shall submit or produce requested documentation in accordance with rules at 10 CCR 2505-10 {section 8.7400}.
        ii. Billing for excessive hours that are not justified by the documentation of services provided, or by the member's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as much time as that authorized.
        iii. Billing for time spent by the personal care provider performing any tasks that are not allowed according to regulations in this 10 CCR 2505-10 section ~~[8.489.]~~ {8.7536}. This includes but is not limited to companionship, financial management, transporting of members, skilled personal care, or delegated nursing tasks.
        iv. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

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a) One employee makes one visit, and the agency bills Medicaid for one home health aide visit and bills all the hours as personal care or homemaker.

b) One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as personal care or homemaker, when the total time spent on the visit does not equal at least 2 1/2 hours plus the number of hours billed for personal care and homemaker.

c) Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 1/2 hours.

d) One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related, to the member's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

e) One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the member's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f) Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

v. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 4 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

vi. Billing for travel time is prohibited.

4. ~~[Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal agent.~~

5. ~~When a personal care agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.~~

B. ~~Supported Living Services (SLS) Waiver:~~

1. ~~SLS providers must comply with requirements found at]~~ [8.500.98 PROVIDER REQUIREMENTS]

8.7536.06 {Personal Care Reimbursement Requirements

A. HCBS Brain Injury (BI) Waiver; Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver:

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1. Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of one hour. The maximum unit rate shall be adjusted by the State as funding becomes available.
2. Payment does not include travel time to or from the member's residence.
3. When personal care services are used to provide respite for unpaid primary caregivers, the exact services rendered must be specified in the documentation.}
4. ~~[When an employee of a personal care agency provides services to a member who is a relative, the personal care agency shall bill under a special procedure code, in hourly units, using rates and hours which shall not exceed a total cost to Medicaid of more than $13.00 per day when averaged out over the number of days in the plan period.]~~
5. {If a visit by a personal care staff includes some homemaker services, the entire visit shall be billed as personal care services. If the visit includes only homemaker services, and no personal care is provided, the entire visit shall be billed as homemaker services.
6. If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.}
7. ~~[Effective 2/1/99,]~~ {There shall be no reimbursement under this section for personal care services provided in certified, uncertified, licensed, or ~~or~~ unlicensed congregate facilities.} ~~[Case managers may submit a written request to the Department for a waiver not to exceed six months for members receiving these services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued.~~
8. ~~Cost Reporting~~
   a. ~~All personal care agencies shall report and submit to the Department cost report information on a Department prescribed form.~~
   b. ~~By dates set forth by the Department, personal care providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or the State fiscal year.~~
   c. ~~Providers that do not comply with this requirement shall have their Medicaid provider agreement terminated.~~

B. ~~HCBS Supported Living Services (SLS) Waiver:~~
   1. ~~SLS providers must comply with requirements found at] [8.500.104 PROVIDER REIMBURSEMENT]~~

8.7536.07 Personal Care Remote Supports Option

A. HCBS Elderly, Blind, and Disabled (EBD) Waiver; Brain Injury (BI) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Supported Living Services (SLS) Waiver:

1. Personal Care Remote Support Option Definitions

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

b. Monitoring base means the off-site location from which the Remote Supports Provider monitors the member.

c. Remote Supports mean the provision of support by staff at a HIPAA compliant Monitoring Base who ~~are~~ engage with a member ~~to~~ through live two-way communication to provide prompts and respond to the member's health, safety, and other needs identified through a person-centered support plan to increase their independence in their home and community when not engaged other HCBS services.

d. Remote support plan is a document that describes the member's need for remote support, devices that will be used, number of service hours, emergency contacts, and a safety plan developed between the member and Remote Supports provider in consultation with their case manager.

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e. Remote Supports provider means the provider agency selected by the member to provide Remote Supports. This provider supplies the monitoring base, the remote support staff who monitor a member from the monitoring base, and the remote support technology equipment necessary for the receiving Remote Supports.

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

2. Personal Care Remote Supports Option Inclusions

a. /Remote Supports provides assistance with eating, bathing, dressing, personal hygiene, activities of daily living that do not require hands-on assistance by staff at a remote location who are engaged with the member to respond to their health, safety, and other needs through technology/devices with the capability of live two-way communication.

b. The service Includes prompting with such housekeeping chores as bed making, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family

c. Help with meal preparation is included, but not the cost of meals.

d. The goal of Remote Supports is to increase autonomy by providing the member an opportunity to build life skills through independent learning using scheduled video calls, cueing, coaching, and on-call support.

e. The member's goals and tasks should be documented in their person-centered support plan\

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

i. Motion sensing system;
ii. Radio frequency identification;
iii. Live audio feed;
iv. Web-based ~~monitoring~~ system; or,
v. Another device that facilitates two-way communication.

g. Remote Supports includes the following general provisions.

i. Remote Supports shall only be approved when it is the member's preference and will reduce the assessed need for in-person care.
ii. The member, their case manager, and the selected Remote Supports provider shall determine whether Remote Supports is sufficient to ensure the member's health and welfare.
iii. Remote Supports shall be provided in real time ~~[, not via a recording,]~~ by awake staff at a Monitoring Base using the appropriate technology. While Remote Support is being provided, the Remote Support staff shall not have duties other than the provision of Remote Supports.

3. Person Care Remote Supports Option Restrictions And Non-Benefit Items

a. Remote Supports shall be authorized only for members who have the physical and mental capacity to utilize the particular system requested for that member.

b. Remote Supports shall not be authorized under HCBS if the service or device is available as a state plan Medicaid benefit.

c. This service is available to members to foster developmentally appropriate independence and not to replace informal support.

d. /Video monitoring by mounted cameras is not allowed. Interactions between the remote support provider and the member should be through live two-way communication that is on-demand, scheduled, or triggered by a sensor.

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e. Devices used for communication cannot be mounted in a bedroom or bathroom but must be able to be moved by the member

f. Remote Support Technology does not include the cost of cell phones, internet access, landline telephone lines, cellular phone voice, and/or data plans necessary for the provision of services./

g. The following are not benefits of Remote Supports:
   i. The cost of cell phones, internet access, landline telephone lines, cellular phone voice, or data plans.
   ii. Augmentative communication devices and communication boards;
   iii. Hearing aids and accessories;
   iv. Phonic ears;
   v. Environmental control units, unless required for the medical safety of a member living alone unattended; or as part of Remote Supports;
   vi. Computers and computer software unrelated to the provision of Remote Supports;
   vii. Wheelchair lifts for automobiles or vans;
   viii. Exercise equipment, such as exercise cycles;
   ix. Hot tubs, Jacuzzis, or similar items.

4. Personal Care Remote Supports Provider Agency Requirements

a. The Remote Supports provider must follow requirements at 8.7400 Provider Agencies Rules and Regulations as outlined in the provider enrollment contract.

b. The Remote Supports provider will meet with the member to identify Remote Support service needs and submit the recommendations in a Remote Support Plan to the member's case manager which must include:
   i. Where the member will receive the service
   ii. A brief description of what the member requests Remote Supports to do for them
   iii. The technology devices necessary to help the member meet their identified needs
   iv. Family or providers the member identified to share information with and a safety plan that includes emergency contact information and medical conditions, if any, that should be noted to emergency response if the provider must call 911 or emergency personnel.

c. Remote Supports providers shall conform to the following standards for electronic monitoring services:
   i. Properly trained individuals shall install all equipment, materials, or appliances, and the installer and/or provider of electronic monitoring shall train the member in the use of the device.
   ii. All equipment, materials, or appliances shall be tested for proper functioning at the time of installation, and at periodic intervals after that, and be maintained based on the manufacturer's recommendations. Any malfunction shall be promptly repaired, and equipment replaced when necessary, including buttons and batteries.
   iii. All telephone calls generated by monitoring equipment shall be toll-free, and all members shall be allowed to run unrestricted tests on their equipment.
   iv. Remote Supports providers shall send written information to each member's case manager about the system, how it works, and how it will be maintained in the Remote Support Plan.
   ~~A. Remote Supports Providers shall conform to the following additional standards for provision of Remote Supports services:~~

~~a) When Remote Supports includes the use of live audio and/or video equipment that permits a Remote Supports Provider to view activities and/or listen to conversations in the residence, the member who receives the service and each person who lives~~

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~~with the member shall consent in writing after being fully informed of what Remote Support entails including, but not limited to:~~

i) ~~The Remote Supports Provider will observe their activities and/or listen to their conversations in the residence;~~
   (1) ~~The location in the residence where the Remote Supports service will take place; and,~~
   (2) ~~Whether or not the Remote Supports provider will record audio and/or video.~~
   (3) ~~If the member or a person who lives with the member has a guardian, the guardian shall consent in writing. The member's Case Manager and Remote Supports Provider shall keep a copy of each signed consent form.~~

d. The Remote Support Provider shall provide a member who receives Remote Supports with initial and ongoing training on how to use the Remote Supports system(s) {including regular assurance that the member knows how to turn on/off systems.}
e. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.
f. The Remote Supports provider shall have a backup power system (such as battery power and/or generator) in place at the Monitoring Base in the event of electrical outages. The Remote Supports Provider shall have additional backup systems and additional safeguards in place which shall include, but are not limited to, contacting the Backup Support Person in the event the Monitoring Base System stops working for any reason.
g. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.
h. If a known or reported emergency involving a member arises, the Remote Supports Provider shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the Backup Support Person. The Remote Supports Provider shall maintain contact with the member during an emergency until emergency personnel or the Backup Support Person arrives.
i. The Backup Support Person shall verbally acknowledge receipt of a request for assistance from the Remote Supports Provider. Text messages, email, or voicemail messages will not be accepted as verbal acknowledgment.
j. When a member requests in-person assistance, the Backup Support Person shall arrive at the member's location within a reasonable amount of time /based on team agreement/ to be specified in documentation maintained by the Remote Support Provider.
k. When a member needs assistance, but the situation is not an emergency, the Remote Supports provider shall:
   i. Address the situation from the Monitoring Base, or,
   ii. Contact the member's Backup Support Person if necessary.
d. The Remote Support Provider shall maintain detailed and current written protocols for responding to a member's needs, including contact information for the Backup Support Person to provide assistance.
e. The Remote Support Provider shall maintain documentation of the protocol to be followed should the member request that the equipment used for delivery of Remote Supports be turned off.
f. The Remote Supports Provider shall maintain daily service provision documentation that shall include the following:
   i. Type of Service,
   ii. Date of Service,
   iii. Place of Service,
   iv. Name of member receiving service,
   v. Medicaid identification number of member receiving service,
   vi. Name of Remote Supports Provider,

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vii. Identify the Backup Support Person and their contact information, if/when utilized.
viii. Begin and end time of the Remote Supports service,
ix. Begin and end time of the Remote Supports service when a Backup Support Person is needed on site,
x. Begin and end time of the Backup Support Person when on site, whether paid or unpaid,
xi. Number of units of Remote Supports service delivered per calendar day,
xii. Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the individual's current Service Plan, which shall be communicated to the individual's case manager.

5. Personal Care Remote Supports Option Reimbursement

a. For Remote Supports, the reimbursement unit shall include one unit per installation/equipment purchase and/or the units as designated on the Department's fee schedule and/or billing manuals for ongoing Remote Supports service.
b. There shall be no reimbursement for Remote Supports in provider-owned or congregate settings.

8.7537 Prevocational Services

8.7537.01 Prevocational Service Eligibility

A. Prevocational services are available to members enrolled in one of the following HCBS waivers:
1. Developmental Disabilities Waiver
2. Supported Living Services Waiver

8.7537.02 Prevocational Service Definition

A. Prevocational services are provided to prepare a member for paid community employment {by increasing general employment skills}. Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the member's private residence or other residential living arrangement.

8.7537.03 Prevocational Service Inclusions

A. Prevocational Services consist of teaching concepts {associated with performing compensated work} including attendance, task completion, problem solving, and safety {skills}.

8.7537.04 Service Access & Authorizations Prevocational Service

A. Prevocational Services are provided to support the member to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual {Person-Centered Support Plan} ~~[service plan]~~ demonstrates this need based on an annual assessment.
B. A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment.
C. Documentation shall be maintained in the file of each member [~~receiving this service]~~ that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. Section 1400 et seq.).

8.7537.05 Prevocational Service Requirements

A. Members shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations and C.R.S. § 8-6-108.7.

8.7537.06 Prevocational Service Exclusions and Limitations

A. Prevocational Services are not primarily directed at teaching job specific skills.
B. One (1) unit is equal to fifteen (15) minutes of service. The following unit limitations apply:

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1. SLS:
   a. Prevocational services, in combination with other Day Habilitation services and Supported Employment services {as defined in 8.7516}, are limited to seven thousand one hundred and twelve (7,112) units per Person-Centered Support Plan year.
2. DD:
   a. Prevocational services, in combination with Day Habilitation services {as defined in 8.7516}, are limited to four thousand eight hundred (4,800) units.

   b. When used in combination with Supported Employment services {as defined in 8.7546}, the total number of units available for Prevocational services in combination with Day Habilitation services will remain at four thousand eight hundred (4,800) units, and the cumulative total, including Supported Employment services, may not exceed seven thousand one hundred and twelve (7,112) units.

8.7538 ~~[Parent]~~{Primary Caregiver} Education (CES)

8.7538.01 Primary Caregiver Education Eligibility

A. Primary Caregiver Education is a service available to members enrolled in the HCBS Children's Extensive Support Waiver.

8.7538.02 Primary Caregiver Education Definition

A. ~~[Parent]~~ {Primary Caregiver} education provides unique opportunities for parents or other [~~care givers~~]{caregivers} to learn how to ~~[Support]~~ {support} the {member's}strengths within the context of the child's disability and enhances their {caregiver's}~~[parent's]~~ ability to meet the ~~[special]~~ needs of the child.

8.7538.03 Primary Caregiver Education Inclusions

A. ~~[Parent education]~~ {Caregiver Education} includes:
   1. Consultation and direct service costs for training parents and other caregivers in techniques to assist in caring for the member's needs, including sign language training,
   2. Special resource materials,
   3. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the member's disability, and
   4. Cost of membership to ~~[parent Support]~~{caregiver support} or information organizations and publications designed for {caregivers}~~[parents]~~ of children with disabilities.

8.7538.04 Primary Caregiver Education Exclusion/Limitations

A. The maximum service limit for ~~[parent]~~ {caregiver}education is one thousand (1,000) units per support plan year.

B. The following items are specifically excluded under the ~~[HCBS]~~ waiver and not eligible for reimbursement:
   1. Transportation;
   2. Lodging;
   3. Food; and
   4. Membership to any political organizations or any organization involved in lobby activities.

8.7539 Residential Habilitation Service~~s~~ and Supports (RHSS) (24 hr. individual or group)

8.7539.01 Residential Habilitation Service~~s~~ and Supports Eligibility

A. Residential Habilitation Service~~s~~ and Supports (RHSS) is a service available to members enrolled in the HCBS Developmental Disabilities Waiver.

8.7539.02 RHSS Definition

A. Residential Habilitation Service~~s~~ and Supports (RHSS) provide a full day (24 hours) of service, supports, and supervision.

8.7539.03 RHSS Inclusions

A. Services are provided to ensure the health, safety and welfare of the member, and to provide training and habilitation services or a combination of training (i.e., instruction, skill acquisition) and supports in the areas of personal, physical, mental and social development and to promote

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independence, self-sufficiency and community inclusion. Services and supports are designed to meet the unique needs of each member determined by the assessed needs, personal goals, and other input provided by the member selected team, defined at Sections 8.7539.A - 8.7539.02.A}, and to provide access to and participation in typical activities and functions of community life.

B. Members receiving RHSS must have 24-hour supervision. Supervision may be on-site (direct service provider or caregiver is present) or accessible (direct service provider or caregiver is not on site but available to respond when needed). Staffing arrangements must be adequate to meet the health, safety and welfare of the member and the needs of the member as determined by the support plan. The provider is responsible for verifying that any direct care provider they employ or contract with has the capacity to serve the members in their care, as outlined in the support plan.

C. Members are presumed able to manage their own funds and possessions unless otherwise documented in the support plan.

D. RHSS includes medical and health care services that are integral to meeting the daily needs of the member.

1. IRSS
   a. IRSS includes skilled care that can be performed by a Certified Nursing Assistant (CNA) or lower.
2. GRSS
   a. GRSS includes nursing services, per 6 CCR 1011-1 Chapter 8, Section 16.

8.7539.04 RHSS Provider Agency Requirements

A. The provider must notify the member, guardians, other legally authorized representatives, and the case manager at least thirty (30) ~~fifteen (15)~~ days prior to proposed changes in setting placements.
   1. If an immediate move is required for the protection of the member, notification must occur as soon as possible before the move or no later than three days after the move. Such notification shall be documented.
   2. The member, guardians, and other legally authorized representatives, as appropriate, must be involved in planning subsequent placements and any member of the member-identified ~~Interdisciplinary~~ team may request a meeting to discuss the change in placement.
   3. When a member moves settings or providers, all residential providers involved must be present for the move whenever possible, and will ensure all possessions, medications, money and pertinent records are transferred to the member within 24 hours.
   4. If the member, guardians, or other legally authorized representative, as appropriate, wants to contest the move they should follow the grievance procedure of the agency.
   5. ~~[If there is a concern regarding the health, safety, or welfare of the member being jeopardized as a result of the move, any interested party may request an emergency order from the Department pursuant to Section 8.605.4.]~~

B. The provider is responsible for the monitoring of conditions at the setting ~~property~~ and must provide oversight and guidance to safeguard the health, safety, and welfare of the member.

C. The provider must provide for and document the regular on-site monitoring of Residential Habilitation Service~~s~~ and Supports. Provider's must conduct an on-site visit of each Individual Residential Service and Support~~s~~ ~~Services~~ (IRSS) or Group Residential Service and Support~~s~~ ~~Services~~ (GRSS) setting before a member moves in, and at a minimum once every quarter, with at least one visit annually that is unscheduled. On-site monitoring of IRSS and GRSS settings must include, but not be limited to:
   1. Inspection of all smoke alarms and carbon monoxide detectors;
   2. Ensuring all exits are free from blockages to egress;
   3. Review of each member's emergency and disaster assessment; and
   4. Medication administration records and physician orders.

8.7540 Individual Residential Service and Supports (IRSS)

8.7540.01 Individual Residential Service and Supports (IRSS) Eligibility

A. Individual Residential Service and Supports (IRSS) is a service available to members enrolled in the HCBS Developmental Disabilities Waiver.

8.7540.02 Individual Residential Service and Supports (IRSS) Definitions

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A. Individual Residential Service~~s~~ and Supports (IRSS) use a variety of living arrangements to meet the unique needs for support, guidance and habilitation of each member.
   1. IRSS settings include, but are not limited to:
      a. A setting ~~home~~ owned, leased or controlled by the provider agency;
      b. A setting ~~home~~ of a family member;
      c. Their own setting ~~home~~; or
      d. A Host Home.
         i. The Host Home is the primary setting ~~residence~~ of the provider, which means that the Host Home provider occupies the setting ~~residence~~ seventy-five (75) percent of the time. The Host Home provider may not contract to provide services to more than three (3) members, inside or outside of the Host Home, at any given time.

8.7540.03 Individual Residential Service and Supports (IRSS) Provider Agency Requirements

A. Oversight
   1. The provider agency is responsible for controlling the daily operations and management of the agency and the residential settings under the agency's purview. The provider must provide sufficient oversight and guidance and have established written procedures to ensure that the health and medical needs of the member are addressed. This includes:
      a. Each member must have a primary physician;
      b. Each member must receive a medical evaluation at least annually unless a greater or lesser frequency is specified by their primary physician. If the physician specifies an annual evaluation is not needed, a medical evaluation must be conducted no less frequently than every two years;
      c. Each member must be encouraged and assisted in getting a dental evaluation annually;
      d. Other medical and dental assessments and services must be completed as the need for these is identified by the physician, dentist, other medical support personnel or the member selected team; and
      e. Records must contain documentation of:
         a. medical services provided;
         b. results of medical evaluations/ assessments and of follow-up services required, if any;
         c. acute illness and chronic medical problems; and,
         d. weight taken annually or more frequently, as needed.
   2. The provider must ensure nutritionally balanced meals are available to members. Based on an assessment of the members capabilities, preferences and nutritional needs, the provider may provide guidance and support to monitor nutritional adequacy.
      i. Therapeutic diets must be prescribed by a licensed physician or dietician.
      ii. Even if recommended by the member's physician or other practitioner, ~~S~~staff interventions that interfere with the member's choice of food, freedom to determine their own activities, or exercise of any other rights are Rights Modifications that must comply with Section 8.7003.D.
      ~~iii. [Members must have access to food at all times, choose when and what to eat, the opportunity to provide input into menu planning, comfortable seating for meals where they can choose their own seat, and shall have access to food preparation areas as documented in the Person-Centered Support Plan.]~~
   3. IRSS may be provided to no more than three members in a single setting. For each member in a setting, the provider must ensure the following criteria are met and documented:
      i. The members involved elect to live in the setting;
      ii. Each member must have their own bedroom, unless they elect to share a bedroom with a roommate of their choice, which must be documented in the support plan;

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iv. Back-up providers are identified, available and agreed upon by the member and provider. When a back-up provider is not available, the provider assumes responsibility for identifying a provider;
v. The provider and case management agency of each member in the setting must be involved in the coordination of placement of each member;
vi. Members are afforded regular opportunities for community inclusion of their choice;
vii. Members are afforded individual choice, including preference to live near family;
viii. Distance from other settings ~~homes~~ (e.g., apartments, houses) of members is examined so that persons with developmental disabilities are not grouped in a conspicuous manner;

4. For the placement of a member into a three-person setting, the following factors must be examined and documented to determine reasonableness of the placement:
   f. Level of care and needs of each member in the setting;
   g. Availability to support and provide supervision to members;
   ~~[Compliance with HCBS Settings Final Rule at 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified in relevant part at 42 C.F.R. § 441.301);]~~ and
   h. Each member's ability to evacuate.
5. When three members reside in a single setting, the provider must conduct monthly monitoring of the setting.
   i. ~~[Members must live safely in environments common to other citizens with reasonable and appropriate supports provided to protect their health and safety while simultaneously promoting community inclusion. Providers and caregivers must have the appropriate knowledge, skills, and training to meet the individual needs of the member before providing care and services. The provider must have policies and procedures in place outlining the required trainings for providers and caregivers. The policy and procedure shall include, but not be limited to, the following:~~
   ii. ~~10.Training specific to the members' needs shall be completed by all providers and caregivers. Such training shall include, at a minimum, medical protocols and activities of daily living needs.~~
   iii. ~~Providers and caregivers shall receive training in resident rights, abuse and neglect prevention, and reporting abuse, neglect, mistreatment and exploitation.]~~
6. Upon enrollment in services, the provider must assess each member's ability to care for their safety needs and take appropriate action in case of an emergency. The assessment must be kept up to date and, at a minimum, address the following emergencies and disasters:
   i. Fire;
   ii. Severe weather and other natural disasters;
   iii. Serious accidents and illness;
   iv. Assaults; and,
   v. Intruders.
7. There must be a written plan for each member addressing how the emergencies specified above will be handled. The plans must be based on an assessment, maintained current and shall, at minimum, address:
   i. Specific responsibilities/actions to be taken by the member, approved caregivers or other providers of supports and services in case of an emergency;
      a. How the member will evacuate in case of fire by specifying, at minimum, two exit routes from floors used for sleeping and the level of assistance needed; and
      b. Telephone access (by the member or with assistance) to the nearest poison control center, police, fire and medical services.
8. Safety plans and evacuation procedures must be reviewed and practiced at sufficient frequency and varying times of the day, but no less than once a quarter, to ensure all persons with responsibilities for carrying out the plan are knowledgeable about the plan

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and capable of performing it. All safety plans must be on site at the setting ~~home~~ and be reviewed by the provider agency during each on-site monitoring visit.

9. Each provider must provide quarterly housing and member updates to the Department or its agent through a specified data collection platform. Failure to provide these quarterly updates may result in payment suspension.

B. Contracts

1. The provider must have a written contract with each direct service provider that is not directly employed by the provider and is providing IRSS under the provider's authority, regardless of the setting type. This includes but is not limited to Host Home providers and family caregivers not directly employed by the provider.
    i. A current list of the above-mentioned contracted IRSS providers and their accompanying contracts must be on file with the program approved service agency and a copy must be provided to the Department or its agent upon request.
    ii. Each contract must be in writing and contain the following information:
        a. Name of contracted IRSS provider;
        b. Responsibilities of each party to the contract, including, but not limited to, responsibility for the safety and accessibility of the physical environment of the setting ~~home~~;
        c. An agreement outlining the living arrangements, monitoring of the Host Home, Host Home provider's duties, and any limitations on the Host Home providers duties;
        d. Expectations that members ~~participants~~ be provided opportunities for informed choice over a variety of daily choices similar to those exercised by non-members ~~nonparticipants~~;
        e. Process for correcting non-compliance;
        f. Process for termination of the contract;
        g. Process for modification or revision of the contract;
        h. Process for relocation of the member if they are in immediate jeopardy of actual or potential for serious injury or harm;
        i. Process for coordinating the care of the member;
        j. Payment rate and method;
        k. Beginning and ending dates; and
        l. A clause that states the contracted IRSS provider shall not sub-contract with any entity to perform in whole the work or services required under the IRSS benefit.

~~[Providers who utilizes the services of subcontractors are responsible for the following, which includes but is not limited to:~~

~~i) Vetting, training, monitoring, and taking corrective action with employees and subcontractors.~~

~~ii) Nothing in these regulations shall create any contractual relationship between any subcontractor of the provider and the Department.]~~

iii. If a contract is terminated with a contracted IRSS provider due to health, safety or welfare concerns, the provider must report to the following parties:
    a. Within four (4) days to the Department or its agent regarding the cited reason for termination of a contracted IRSS provider.
    b. Within four (4) days to the guardian or other legally authorized representative and case manager of the member ~~from the terminated contracted IRSS provider.~~

iv. The provider must require each contracted direct service provider providing IRSS to document each approved caregiver(s) and report to the agency the names of all persons that reside in the setting ~~home~~. Members and/or guardians have a right to request and receive from the rendering provider a list of all direct service and backup providers that are approved to provide them services. No backup provider may be hired without provider approval. The agency must ensure

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criminal background checks are completed for any non-member over the age of eighteen (18) who lives in the setting ~~home~~.

v. The IRSS direct service provider is prohibited from conduct that would pose a risk to the health, safety and welfare of the member including the members mental health.

C. Living Environment

1. The provider has the responsibility for the living environment, regardless of the setting type.
2. Settings of members must, at minimum, meet standards set forth in the Colorado Division of Housing (DOH) IRSS Inspection Protocol. The following setting types must pass the DOH IRSS Inspection Protocol every two years:
   i. All Host Homes; and
   ii. All IRSS settings that are owned or leased by a provider.
      a. All IRSS settings must be announced to and recorded by DOH within 90 days of activation by a provider and the placement of a member
      b. An inspection by DOH is not required prior to the placement of a member if the setting has been inspected by the provider and passes all residential safety requirements.
3. The provider must have a protocol in place for the emergency placement of the member if a setting ~~home~~ is deemed not safe by the Division of Housing (DOH)
4. The setting (exterior and interior) and grounds must:
   i. Be maintained in good repair;
   ii. Protect the health, comfort and safety of the member; and
   iii. Be free of offensive odors, accumulation of dirt, rubbish and dust.
5. There must be two means of exit from floors with rooms used for sleeping. Exits must remain clear and unobstructed.
6. The provider must ensure entry to the setting and an emergency exit is accessible to members, including members utilizing a wheelchair or other mobility device.
7. ~~The provider must ensure that members who utilize a wheelchair or other mobility device have access to all common areas of the home~~
8. Bedrooms must meet minimum space requirements (single 100 square feet, double 80 square feet per person). (Not applicable for studio apartments.)
9. Adequate and comfortable furnishings and supplies must be provided and maintained in good condition.
10. ~~Members have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment.~~
11. A fire extinguisher must be available in each setting. Presence of an operational fire extinguisher shall be confirmed by the provider during each on-site monitoring visit.
    i. Provider's must follow manufacturer specifications and expiration dates for all fire extinguishers.
12. Smoke alarms and carbon monoxide detectors must be installed in the proper locations in each home to meet Housing and Urban Development (HUD) requirements and/or local ordinances. Smoke and carbon monoxide detectors shall be tested during each on-site monitoring visit by the provider.

8.7541 Group Residential Service~~s~~ and Supports (GRSS)

8.7541.01 Group Residential Service~~s~~ and Supports Eligibility

A. Group R~~r~~esidential S~~s~~ervice~~s~~ and S~~s~~upports (GRSS) is a service available to members enrolled in the HCBS Developmental Disabilities Waiver.

8.7541.02 Group Residential Services and Supports Definitions

A. Group R~~r~~esidential S~~s~~ervice~~s~~ and S~~s~~upports (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) members receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment (CDPHE) as a residential care facility or residential community setting ~~home~~ for members with developmental disabilities.

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1. GRSS is a licensed setting and must comply with all regulations set forth at 6 CCR 1011-1 Chapter 8.

8.7541.03 Group Residential Service~~s~~ and Supports Provider Reimbursement Requirements

A. Reimbursement for GRSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of members or to meet the requirements of the applicable life safety code.

8.7542 Respite {(Adult)}

8.7542.01 Adult Respite Eligibility

A. Adult Respite is a service available to members enrolled in one of the following HCBS waivers:
   1. Brain Injury Waiver
   2. Community Mental Health Supports Waiver
   3. Complementary and Integrative Health Waiver
   4. Elderly, Blind, and Disabled Waiver
   5. Supported Living Services Waiver

8.7542.02 Adult Respite Definition

A. Adult Respite care means services provided to an eligible member on a short-term basis because of the absence or need for relief of those persons who normally provide the care.

8.7542.03 Adult Respite Inclusions

A. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver
   1. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite member, as ordered by the physician.
   2. An alternative care facility shall provide all the alternative care facility services as listed at [8.7505], which are required by the individual respite member.
   3. {Respite may be provided in the member's home, home of the respite provider, or in the community.}

B. HCBS Brain Injury (BI) Waiver
   1. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite member, as ordered by the physician.
   2. {Respite may be provided in the member's home, home of the respite provider, or in the community.}

C. HCBS Supported Living Services (SLS) Waiver
   1. Respite may be provided in the member's home;
   2. The private residence of a respite care provider; or
   3. In the community.

8.7542.04 Adult Respite Exclusions and Limitations

A. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver:
   1. An individual member shall be authorized for no more than thirty (30) days of respite care in each support plan year unless otherwise authorized by the Department.
   2. Alternative care facilities shall not admit individuals for respite care who are not appropriate for alternative care facility placement, as specified at [8.7505].
   3. Only those portions of the facility that are Medicaid certified for nursing facility or alternative care facility services may be utilized for respite members.

B. HCBS Brain Injury (BI) Waiver
   1. An individual member shall be authorized for no more than a cumulative total of thirty (30) days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home and in a nursing facility.
      a. A mix of delivery options is allowable if the aggregate amount of services is below thirty (30) days, or 720 hours, of respite care.

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b. In-home respite is limited to no more than eight (8) hours per day.
c. Nursing facility respite is billed on a per diem.
d. Only those portions of the facility that are Medicaid certified for nursing facility services may be utilized for respite members.

C. HCBS Supported Living Services (SLS) Waiver
1. ~~[Federal financial participation shall not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved pursuant to. by the state that is not a private residence.]~~
2. Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.
3. Respite shall be reimbursed according to a unit rate or daily rate, whichever is less.

8.7542.05 Adult Respite Provider Agency Requirements

A. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver
1. Respite care standards and procedures for nursing facilities are as follows:
a. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such **{a}** contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.
b. The nursing facility does not have to maintain or hold open separately designated beds for respite members but may accept respite members on a bed available basis.
c. For each HCBS-BI/EBD/CIH/CMHS respite member, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the member. The chart must identify the member as a respite member. If the respite stay is for fourteen (14) days or longer, the {Minimum Data Set (MDS)} must be completed.
d. An admission to a nursing facility under HCBS-BI/EBD/CIH/CMHS respite does not require a new \Level of Care Screen,\ ~~[ULTC-100.2,]~~ a PASRR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.
e. The nursing facility shall have written policies and procedures available to staff regarding respite care members. Such policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care members.
f. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite member's entry into the facility.
2. Respite care standards and procedures for alternative care facilities are as follows:
a. The alternative care facility shall have a valid contract with the Department as a Medicaid certified HCBS-EBD/CMHS alternative care facility provider. Such contract shall constitute automatic certification for HCBS-BI/EBD/CIH/CMHS respite care.
b. For each respite care member, the alternative care facility shall follow normal procedures for care planning and documentation of services rendered.
3. Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

B. HCBS Brain Injury (BI) Waiver
1. Respite care standards and procedures for nursing facilities are as follows:
a. The nursing facility must have a valid contract with the State as a Medicaid

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certified nursing facility. Such {a} contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

b. The nursing facility does not have to maintain or hold open separately designated beds for respite members but may accept respite members on a bed available basis.

c. For each HCBS-BI/EBD/CIH/CMHS respite member, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the member. The chart must identify the member as a respite member. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

d. An admission to a nursing facility under HCBS-BI/EBD/CIH/CHMS respite does not require a new ULTC-100.2, a PASRR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

e. The nursing facility shall have written policies and procedures available to staff regarding respite care members. Such policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care members.

f. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite member's entry into the facility.

2. Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

C. ~~[HCBS Supported Living Services (SLS) Waiver~~

1. ~~A private for profit or not for profit agency or government agency shall meet minimum provider qualifications as set forth in the HCBS-SLS waiver and shall:~~

a. ~~Conform to all state established standards for the specific services they provide under HCBS-SLS,~~

b. ~~Maintain program approval and certification from the Operating Agency,~~

c. ~~Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in Section 8.130, 4. Discontinue HCBS-SLS services to a member only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.~~

d. ~~Have written policies governing access to duplication and dissemination of information from the member's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S.~~

e. ~~When applicable, maintain the required licenses from the Colorado Department of Public Health and Environment, and~~

f. ~~Maintain member records to substantiate claims for reimbursement according to Medicaid standards.]~~

8.7542.06 Adult Respite Provider Reimbursement Requirements

A. HCBS Brain Injury (BI) Waiver; Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver

1. Respite care reimbursement to nursing facilities shall be as follows:

a. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-BI/EBD/CIH/CMHS claim form according to fiscal agent instructions.

b. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four-hour day of respite provided by the nursing

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facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

c. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

d. Respite care reimbursement to alternative care facilities shall be as follows:

i. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four-hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

e. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

2. Individual respite providers shall bill according to a unit rate or daily institutional Nursing Facility rate, whichever is less.
3. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI/EBD/CIH/CMHS services shall not be reimbursed during the respite stay.
4. There shall be no reimbursement provided under this section for respite care in uncertified congregate facilities.

B. HCBS Supported Living Services (SLS) Waiver:

1. Respite shall be provided according to individual, or group rates as defined below:
   a. Individual: the member receives respite in a one-on-one situation. There are no other members in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty-four (24)-hour period.
   b. Individual Day: the member receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period.
   c. Overnight Group: the member receives respite in a setting which is defined as a facility that offers 24-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.
   d. Group: the member receives care along with other individuals, who may or may not have a disability. The total cost of the group rate within a 24-hour period shall not exceed the respite daily rate.

8.7543 Respite {(Child)}

8.7543.01 Child Respite Eligibility

A. Child Respite is a service available to members enrolled in one of the following HCBS waivers:
   1. Children with Life Limiting Illness
   2. Children's Extensive Support Waiver
   3. Children's Habilitation Residential Program

8.7543.02 Child Respite Definition

A. Child Respite care means services provided to an eligible member on a short-term basis because of the absence or need for relief of those persons who normally provide the care.

8.7543.03 Child Respite Inclusions

A. HCBS Children's Extensive Supports (CES) Waiver
   1. Respite may be provided in the member home or private residence;
   2. The private residence of a respite care provider; or
   3. In the community.

B. HCBS Children with Life Limiting Illness (CLLI) Waiver
   1. Respite care may be provided in the home;
   2. In the community; or

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3. In an approved respite center location of a member.

B. HCBS Children's Habilitation Residential Program Waiver (CHRP) Waiver
1. Respite services may be provided in a certified Foster Care Home;
2. Kinship Foster Care Home;
3. Licensed Residential Child Care Facility;
4. Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours);
5. in the Family home; or
6. or in the community.
7. Overnight out of home Respite must be in a Foster Care Home, Kinship Home, Group Home, or Residential Child Care Facility (RCCF).

8.7543.04 Child Respite Exclusions and Limitations

A. HCBS Children's Extensive Supports (CES) Waiver
1. Respite is to be provided in an age-appropriate manner. A member eleven (11) years of age and younger, cannot receive respite during the time the primary caregiver works, pursues continuing education or volunteers, because this is a typical expense for all ~~[parents]~~ {primary caregivers} of young children.
2. When the cost of care during the time the ~~[parent]~~{caregiver} works is more for a member, eleven (11) years of age or younger, then it is for same age peers, then respite may be used to pay the ~~[additional]~~{difference in costs} cost. ~~[Caregivers]~~ {caregivers} shall be responsible for the basic and typical cost of childcare.
3. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of the member when supervision is needed so the primary caregiver can take the member to receive a state plan benefit or an HCBS-CES waiver service.

B. HCBS Children with Life Limiting Illness (CLLI) Waiver
1. Respite care shall not be provided at the same time as state plan Home Health or Palliative/Supportive Care services.

~~C. [CHRP~~
~~1. Federal financial participation is not available for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.]~~

8.7543.05 Child Respite Provider Reimbursement Requirements

A. HCBS Children's Extensive Supports (CES) Waiver
1. Respite shall be provided according to an individual or group rates as defined below: Individual: the member receives respite in a one-on-one situation. There are no other members in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty-four (24)-hour period.
2. Individual day: the member receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty-four (24)-hour period. A full day is ten (10) hours or greater within a twenty-four (24)- hour period.
3. Overnight group: the member receives respite in a setting which is defined as a facility that offers twenty-four (24)-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty-four (24)-hour period shall not exceed the respite daily rate.
4. Group: the member receives care along with other individuals, who may or may not have a disability. The total cost of the group rate within a twenty-four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:
   a. Sibling care is not allowed for care needed due to ~~[parent's]~~ {caregiver's} work, volunteer, or education schedule or for ~~[parental]~~ {caregiver} relief from care of the sibling.
5. ~~[Federal financial participation shall not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to [Section 8.602 (to be updated)] by the state that is not a private residence.]~~
6. The total amount of respite provided in one support plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual

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units. The Department may approve a higher amount based on a need due to the member's age, disability or unique family circumstances.

7. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or other services not covered by the HCBS-CES waiver.
8. Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.
9. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a member. Therefore, additional respite units beyond the service limit will not be approved for members who receive skilled nursing, certified nurse aide services, or home care allowance from the primary caregiver.

B. HCBS Children with Life Limiting Illness (CLLI) Waiver
   1. Respite is not to exceed thirty (30) days per support plan year, as determined by the Department approved Assessment.

C. HCBS Children's Habilitation Residential Program Waiver (CHRP) Waiver
   1. The total amount of respite provided in one support plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units, where one unit is equal to 15 minutes. The Department may approve a higher amount when needed due to the member's age, disability or unique family circumstances.
   2. During the time when Respite care is occurring, the Foster Care Home or Kinship Care Home may not exceed six (6) foster children or a maximum of eight (8) total children, with no more than two (2) children under the age of (two) 2. The respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.
   3. Respite is available for children or youth living in the Family home and may not be utilized while the member is receiving Habilitation services.

8.7544 Specialized Medical Equipment and Supplies

8.7544.01 Specialized Medical Equipment and Supplies Eligibility

A. Specialized medical equipment and supplies is a service available to members enrolled in one of the following HCBS waivers:
   1. Brain Injury Waiver
   2. Children's Extensive Support Waiver
   3. Developmental Disabilities Waiver
   4. Supported Living Services Waiver

8.7544.02 Specialized Medical Equipment and Supplies Definition

A. Specialized medical equipment and supplies means devices, controls, or appliances that help the member perceive, control, or communicate with their environment to increase their ability to perform activities of daily living or remain safely in their home and community.

8.7544.03 Specialized Medical Equipment and Supplies Inclusions

A. Specialized medical equipment and supplies include devices, controls, or appliances that help the member perceive, control, or communicate with their environment to increase their ability to perform activities of daily living or remain safely in their home and community.
B. Devices, controls or appliances that enable the member to increase their ability to perform activities of daily living,
C. Devices, controls or appliances that enable the member to perceive, control or communicate within their environment,
D. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
E. Durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to member's needs assessed in the person-centered support plan;
F. Necessary medical supplies in excess of Medicaid State Plan limitations or not available under the Medicaid State Plan.
G. Maintenance and upkeep of specialized medical equipment purchased through the HCBS waiver.

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H. All items shall meet applicable standards of manufacture, design and installation.
I. HCBS Supported Living Services Waiver, Children's Extensive Supports Waiver
   1. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;
   2. Specially designed clothing for a member if the cost is over and above the costs generally incurred for a member's clothing;
   3. Specially designed clothing for a member if the cost is over and above the costs generally incurred for a member's clothing;

8.7544.04 Specialized Medical Equipment and Supplies Exclusions and Limitations

A. Specialized medical equipment and supplies exclude those items that are not of direct medical or remedial benefit to the member as assessed through their person-centered support plan.
B. Durable and non-durable medical equipment available under the Medicaid State Plan
C. Items that are not of direct medical or remedial benefit to the member include vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items and wipes for any purpose other than incontinence are not covered under this service.

8.7545 Substance Use Counseling

8.7545.01 Substance Use Counseling Eligibility

A. Substance Use Counseling is a service available to members enrolled in the HCBS Brain Injury Waiver.

8.7545.02 Substance Use Counseling Definition

A. ~~[Substance abuse programs are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the water member.~~ [Substance Use Counseling services are designed to support the member in managing and/or overcoming substance use] which, if not effectively dealt with, may interfere with the ~~[individual's]~~ [member's] ability to remain integrated in the community. {These services are in addition to counseling services available through State Plan services and are not intended to replace these services.}

8.7545.03 Substance Use Counseling Inclusions

A. ~~{Only outpatient individual, group, and family counseling services are available through the brain injury waiver program}~~ {Outpatient individual, group, and family counseling services can be provided in the home, community, or provider's office.}
B. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver member, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons if directly involved in the support system of the member, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager.
C. ~~[Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of {modalities} {counseling services}. Re-authorization requests shall [he] [be] submitted to the State Brain Injury Program [Coordinator].]~~ {The service is limited to ~~-~~thirty visits of individual, group, family or a combination of counseling services. The Department may authorize additional units based on needs identified in the support plan}.

8.7545.04 Substance Use Counseling Exclusions and Limitations

A. Inpatient treatment is not a covered benefit.

8.7545.05 Substance Use Counseling Provider Agency Requirements

A. Substance abuse services may be provided by any agency or individual licensed by the Behavioral Health Administration (BHA) and jointly certified by the Department of Health Care Policy and Financing.
B. Providers must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to members with substance abuse problems. The provider should promote training to improve the ability of the community resources to provide ongoing support to members living with a brain injury.
C. Counselors should be certified at the Certified Addiction Specialist, Licensed Addictions Counselor level or a doctoral level psychologist with the same level of experience in substance abuse

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counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any ~~[individual]~~ [member with a brain injury or their family members.

8.7545.06 Substance Use Counseling Reimbursement

A. Reimbursement will be on an hourly basis per ~~{modality}~~ {counseling service} as established by the Department. There are three separate ~~{modalities}~~ {counseling services} allowable under HCBS-BI counseling services including Family Counseling (if the member is present), Individual Counseling, and Group Counseling.

8.7546 Supported Employment

8.7546.01 Supported Employment Service Eligibility

A. Supported Employment services are available to members enrolled in one of the following HCBS waivers:
   1. Developmental Disabilities Waiver
   2. Supported Living Services Waiver

8.7546.02 Supported Employment Service Definition

A. ~~[Supported Employment services includes intensive, ongoing supports that enable a member, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the member's disabilities needs supports to perform in a regular work setting.]~~ {Supported Employment services are provided to members who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive employment, customized employment, or self-employment. The outcome of this service is sustained paid employment in a job that meets personal and career goals. The job must be in an integrated setting in the general workforce and must be compensated at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The Supported Employment services are Job Development, Job Placement, Job Coaching, and Workplace Assistance.}

8.7546.03 Supported Employment Service Inclusions

A. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development and assisting the member to locate a job or job development on behalf of the member.

B. Supported employment may be delivered in a variety of settings in which members have the opportunity to interact regularly with individuals without disabilities, other than those individuals who are providing services to the member.

C. Supported employment {supports members in achieving sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.} ~~[provided in community jobs, enclaves or mobile crews].~~

D. {Group employment services (e.g. mobile crews) are available to a small group of members (two or more), not exceeding eight persons, and are provided in community business and industry settings} ~~[Group employment including mobile crews or enclaves shall not exceed eight members.]~~

E. Supported employment includes activities needed to sustain paid work by members including supervision and training.

F. If a member is employed, the supervision the member needs while at work shall be clearly documented in their Person-Centered Support Plan (PCSP). A member's supervision level at work must be based on the member's specific work-related support needs.
   1. The level of supervision by paid caregivers may be lower at work than in other community settings, and the member should not be over-supported or limited in their ability to work based on supervision needs identified for other settings.

8.7546.04 Supported Employment Service Access and Authorizations

A. Documentation of the member's application for services through the Colorado Department of Labor and Employment Division for Vocational Rehabilitation shall be maintained in the file of each member receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. Section 1400, et seq.).

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B. Supported Employment services, in combination with Day Habilitation and Prevocational services are limited to seven thousand one hundred and twelve (7,112) units per ~~[service]~~ {support} plan year. One (1) unit equals fifteen (15) minutes of service.

8.7546.05 Supported Employment Service Exclusions and Limitations

A. ~~[When supported employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a member as a result of the member's disabilities.]~~ {Supported Employment services do not include payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business.}

B. Supported employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

C. Supported employment shall not take the place of nor shall it duplicate services received through the Division for Vocational Rehabilitation.

D. The following are not a benefit of supported employment and shall not be reimbursed:
   1. Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment;
   2. Payments that are distributed to users of supported employment; and
   3. Payments for training that are not directly related to a member's supported employment.

E. ~~[Supported employment is work outside of a facility-based site, that is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities].~~{Supported Employment, including group employment, does not include services provided in a facility-based work setting or other similar types of vocational services furnished in specialized facilities that are owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities, or settings that are not part of general community workplaces.}

8.7546.06 Supported Employment Service Provider Agency Requirements

A. {Supported Employment service providers, including Supported Employment professionals who provide individual competitive integrated employment, as defined in 34 C.F.R. 361.5(c)(9) (2018), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and certification requirements. The incorporation of 34 C.F.R. 361.5(c)(9) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of the incorporated material will be provided at cost upon request.

B. Subject to the availability of appropriations for reimbursement in section 8.7546.07. Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

C. Deadlines.
   1. Existing staff employed by the Provider on or before July 1, 2019 must obtain a Training Certificate or a Certification no later than July 1, 2024.
   2. Newly hired staff, employed by the Provider after July 1, 2019 must obtain a Training Certificate or a Certification no later than July 1, 2024.
   3. Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

D. Department approval required.
   1. The Training Certificate or Certification required under section 8.7546.06.B must be pre-approved by the Department. Providers must submit the following information to the Department for pre-approval review:
      a. Provider name.
      b. A current Internal Revenue Service Form W-9.
      c. Seeking approval for:
         i. Training Certificate, or

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ii. Certification, or
iii. Training Certificate and Certification.

d. Name of training, if applicable, including:
i. Number of staff to be trained.
ii. Documentation that the training is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.
iii. Name of Certification, if applicable, including:
a) Number of staff to receive Certification.
b) Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.
iv. Dates of training, if applicable, including whether a certificate of completion is received.
v. Date of Certification exam, if applicable.

2. Department approval will be based on alignment with the following core competencies:
a. Core values and principles of Supported Employment, including the following:
i. The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.
b. The Person-centered process, including the following:
i. The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-centered approach includes working with a team where the individual chooses the people involved on the team and receives necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.
c. Individualized career assessment and planning, including the following:
i. The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.
d. Individualized job development, including the following:
i. Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.
e. Individualized job coaching, including the following:
i. Providing necessary workplace supports to members with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.
f. Job Development, including the following:
i. Effectively engaging employers for the purpose of community job development for members with significant disabilities, which meets the needs of both the employer and the member

3. The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and

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notify the Provider of its determination within 30 days of receiving the pre-approval request under 8.7546.06.D.1}

8.7546.07 Supported Employment Provider Reimbursement Requirements

A. Reimbursement for a Supported Employment Training Certificate or Certification, or both, under section 8.7546.06.B, which includes both the cost of attending a training or obtaining a certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse provider agencies for such costs.

1. Providers seeking reimbursement for completed training or certification, or both, approved under section 8.7546.06.D.3, must submit the following to the Department:
   a. Supported Employment providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.
      i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.
2. Within 30 days of receiving a reimbursement request under section 8.7546.07.A.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under section 8.7546.06.D and either notify the provider of the denial or, if approved, reimburse the provider.
   a. Reimbursement is limited to the following amounts and includes reimbursement for wages:
      i. Up to $300 per certification exam.
      ii. Up to $1,200 for each training.

8.7547 Supported Living Program

8.7547.01 Supported Living Program Eligibility

A. Supported Living Program is a service available to members enrolled in the HCBS Brain Injury Waiver

8.7547.02 Supported Living Program Definitions

A. The Supportive Living Program (SLP) means an Assisted Living Residence as defined at 6 CCR 1011-1, Chapter VII, Section 2, which has been licensed by the Colorado Department of Public Health and Environment (CDPHE) and has been certified by the Department to provide SLP services to Medicaid members. SLP is a specialized assisted living service for members with brain injuries. Settings are certified. Services include 24-hour oversight, assessment, training and supervision of self-care, medication management, behavioral management, and cognitive supports. They also include interpersonal and social skills development.

8.7547.03 Supported Living Program Inclusions

A. SLP services consist of structured services designed to provide:
1. Assessment;
2. Protective Oversight and supervision as defined at 8.7505.02.B;
3. Behavioral Management and Education;
4. Independent Living Skills Training in a group or individualized setting to support:
   a. Interpersonal and social skill development;
   b. Improved household management skills; and
   c. Other skills necessary to support maximum independence, such as financial management, household maintenance, recreational activities and outings, and other skills related to fostering independence.
5. Community Participation;
6. Transportation between therapeutic activities in the community;
7. Activities of Daily Living (ADLs);
8. Personal Care and Homemaker services; and

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9. Health Maintenance Activities.
10. The SLP provider shall ensure that each member is furnished with their own personal hygiene and care items. These items are to be considered basic in meeting a member's need for hygiene and remaining healthy. Any additional items may be selected and purchased by the member at their discretion.

B. Person-Centered Support Planning
1. SLP providers must comply with the Person-Centered Support Planning process. Providers must work with case management agencies to ensure coordination of a member's Person-Centered Support Plan. Additionally, SLP providers must provide the following actionable plans for all BI waiver members, updated every six (6) months:
   a. Transition Planning; and
   b. Goal Planning.
2. These elements of a Person-Centered Support Plan are intended to ensure the member actively engages in their care and activities and is able to transition to any other type of setting or service when desired.

8.7547.04 Supported Living Program Exclusions and Limitations

A. The following are not included as components of the SLP:
1. Room and board shall not be a benefit of SLP services, per 10 CCR 2505-10 {8.74~~50~~14}.
2. Additional services which are available as a State Plan benefit or other BI waiver service. Examples include, but are not limited to physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, long-term home health, and private duty nursing.

8.7547.05 Supported Living Program Provider Agency Requirements

A. Staffing
1. The SLP provider shall ensure sufficient staffing levels to meet the needs of members.
2. The operator, staff, and volunteers who provide direct member care or protective oversight must be trained in precautions and emergency procedures, including first aid, to ensure the safety of the member. Within one month of the date of hire, the SLP provider shall provide adequate training for staff on each of the following topics:
   a. Crisis prevention;
   b. Identifying and dealing with difficult situations;
   c. Cultural competency;
   d. Infection control; and
   e. Grievance and complaint procedures.
3. In addition to the requirements of 6 CCR 1011-1 Ch. 7, the Department requires that the program director shall have an advanced degree in a health or human service-related profession plus two years of experience providing direct services to persons with a brain injury. A bachelor's or nursing degree with three years of similar experience, or a combination of education and experience shall be an acceptable substitute.
4. The SLP shall ensure that provision of services is not dependent upon the use of members to perform staff functions. Volunteers may be utilized in the home but shall not be included in the provider's staffing plan in lieu of employees.

B. Environmental and Maintenance Requirements

~~Members shall be allowed free use of all common living areas within the residence, with due regard for privacy, personal possessions, and safety of members.~~

1. SLP providers shall develop and implement procedures for the following:
   a. Handling of soiled linen and clothing;
   b. Storing personal care items;
   c. General cleaning to minimize the spread of pathogenic organisms; and
   d. Keeping the home free from offensive odors and accumulations of dirt and garbage.

8.7547.06 Supported Living Program Provider Reimbursement Requirements

A. {Room and board shall not be a benefit of SLP services.~~, per 10 CCR 2505-10 8.7414.~~

B. SLP services shall be reimbursed according to a tiered per diem rate based on member acuity, using a methodology determined by the Department.

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C. SLP services are subject to Post Eligibility Treatment of Income (PETI), as outlined in 8.~~7446.05~~509.17.}

8.7548 Therapeutic Life Limiting Illness Support ~~[and Bereavement Counseling]~~

8.7548.01 Therapeutic Life Limiting Illness Support Eligibility

A. Therapeutic Life Limiting Illness Support is a service available to members enrolled in the HCBS Children's with Life Limiting Illness Waiver.

8.7548.02 Therapeutic Life Limiting Illness Support ~~Description~~Definition

A. Therapeutic Life Limiting Illness Support ~~[means grief/loss or anticipatory grief counseling that assist the member and family to decrease emotional suffering due to the member's health status, to decrease feelings of isolation[,] or to cope with the member's life limiting diagnosis. Support]~~ is intended to help the member and family in the disease process. Support is provided to the member to decrease emotional suffering due to health status and develop coping skills. Support is provided to the member and/or family members in order to guide and help them cope with the member's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child.

8.7548.03 Therapeutic Life Limiting Illness Support Inclusions, Exclusions and Limitations

A. Support includes but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the family with community resources such as funding or transportation.

B. Therapeutic Life Limiting Illness Support may be provided in individual or group ~~[setting]~~, [settings].

C. Therapeutic Life Limiting Illness Support shall only be a benefit if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

D. Therapeutic Life Limiting Illness Support is limited to the member's assessed need up to a maximum of 98 hours per annual certification period.

8.7548.04 Therapeutic Life Limiting Illness Support Provider Requirements

A. Individuals providing Therapeutic Life Limiting Illness Support ~~[and Bereavement Counseling]~~ shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

B. Individuals providing Therapeutic Life Limiting Illness Support shall be one of the following:
   1. Licensed Clinical Social Worker (LCSW)
   2. Licensed Professional Counselor (LPC)
   3. Licensed Social Worker (LSW)
   4. Licensed Independent Social Worker (LISW)
   5. Licensed Psychologist; or

C. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice agency.

8.7549 Transition Setup

8.7549.01 Transition Setup Eligibility

A. Transition Setup is a service available to members enrolled in one of the following HCBS waivers:
   1. Brain Injury Waiver
   2. Community Mental Health Supports Waiver
   3. Complementary and Integrative Health Waiver
   4. Developmental Disabilities Waiver
   5. Elderly, Blind, and Disabled Waiver
   6. Supported Living Services Waiver

8.7549.02 Transition Setup Definition

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

8.7549.03 Transition Setup Inclusions

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A. Transition Setup assists the member by coordinating the purchase of items or services needed to establish a basic household and to ensure the home environment is ready for move-in with all applicable furnishings set up and operable; and
B. Transition Setup allows up to $1500 in funds to cover the purchase of one-time, non-recurring expenses necessary for a member to establish a basic household as they transition from an institutional setting to a community setting. Allowable expenses include:
    1. Security deposits that are required to obtain a lease on an apartment or home.
    2. Setup fees or deposits to access basic utilities or services (telephone, internet, electricity, heat, and water).
    3. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.
    4. Essential household furnishings required to occupy, including furniture, window coverings, food preparation items, or bed or bath linens.
    5. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.
    6. Housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal background check.

8.7549.04 Transition Setup Service Access and Authorization

A. To access Transition Setup, a member must be transitioning from an institutional setting or Regional Center to a community living arrangement and participate in a needs-based assessment through which they demonstrate a need for the service based on the following:
    1. The member demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a member to establish a basic household in the community;
    2. The need demonstrates risk to the member's health, safety, or ability to live in the community; or
    3. Other services/resources to meet need are not available.
B. The member 's assessed need must be documented in the member 's Transition Plan and Person-Centered Support Plan.

8.7549.05 Transition Setup Exclusions and Limitations

A. Transition Setup may be used to coordinate or purchase one-time, non-recurring expenses up to thirty (30) days post-transition.
B. ~~Transition Setup expenses include up to $1500 must not exceed a total of $1,500 per eligible member. 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 member.~~
C. Transition Setup does not substitute for services available under the Medicaid State Plan, other waiver services, or other resources.
D. Transition Setup is not available to a member transitioning to, or residing in, a provider-owned or provider-controlled setting.
E. Transition Setup does not include payment for room and board.
F. Transition Setup does not include rental or mortgage expenses, ongoing food costs, regular utility charges, cable or satellite services.
G. Transition Setup is not available for a transition to a living arrangement that does not match or exceed HUD certification criteria.
H. Transition Setup does not include appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television, gaming, or video equipment).

8.7549.06 Transition Setup Provider Agency Requirements

A. The provider shall ensure all products and services delivered to the member shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

8.7549.07 Transition Setup Documentation

A. The provider must maintain receipts for all services and/or items procured for the member. These must be attached to the claim and noted on the Prior Authorization Request.

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B. Providers must submit to the Case Management Agency the minimum documentation of the transition process, which includes:
   1. A Transition Services Referral Form,
   2. Release of Information (confidentiality) Forms, and
   3. A Transition Setup Authorization Request Form.

C. The provider must furnish to the member a receipt for any services or durable goods purchased on the member's behalf.

8.7549.08 Transition Setup Provider Agency Reimbursement

A. Transition Setup Coordination is reimbursed according to the number of units billed, with one unit equal to 15-minutes of service. The maximum number of Transition Setup units eligible for reimbursement is 40 units per eligible member.

B. Transition Setup Expenses must not exceed $1,500 per eligible member. The Department may authorize additional funds above the $1,500 limit, up to $2,000, when the member demonstrates additional needs, and if the expense(s) would ensure the member's health, safety and welfare.

C. Reimbursement shall be made only for items or services described in the person-centered support plan with accompanying receipts.

D. When Transition Setup is furnished to individuals returning to the community from an institutional setting through enrollment in a waiver, the costs of such services are billable when the person leaves the institutional setting and is enrolled in the waiver.

~~[Transition Support]~~

~~I. Transition Support align[s] strategies, interventions, and supports for the member, and family, when a member transitions to the family home from out-of-home placement.~~

~~II. Transition Support Inclusions~~

~~A. Services include:~~

~~1. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the member and family.~~

~~2. Identification of transition needs including, but not limited to:~~

~~i. Cause(s) of a crisis and triggers that could lead to a crisis.~~
~~ii. Physical and behavioral health factors.~~
~~iii. Education services.~~
~~iv. Family dynamics.~~
~~v. Schedules and routines.~~
~~vi. Current or history of police involvement.~~
~~vii. Current or history of medical and behavioral health hospitalizations.~~
~~viii. Current services.~~
~~ix. Adaptive equipment needs.~~
~~x. Past interventions and outcomes.~~
~~xi. Immediate need for resources.~~
~~xii. Respite services.~~
~~xiii. Predictive Risk Factors.~~
~~xiv. Increased Risk Factors.]~~

8.7550 Transitional Living Program

8.7550.01 Transitional Living Program Eligibility

A. Transitional living Program is a service available to members enrolled in the HCBS Brain Injury Waiver.

8.7550.02 Transitional Living Program Definition

A. The Transitional living Program is a residential service designed to improve the member's ability to live in the community by provision of 24-hour services, support and supervision.

8.7550.03 Transitional Living Program Inclusions

A. All services must be documented in an approved plan of care and be prior authorized by the Department.

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B. Program services include but are not limited to assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household.
C. Extraordinary therapeutic needs mean, for purposes of this program, a member who requires more than three hours per day of any combination of therapeutic disciplines. This includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

8.7550.04 Transitional Living Program Exclusions and Limitations

A. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a member requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for the Transitional Living Program service for a member must be documented and authorized individually by the Department.
B. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges.
C. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.
D. Room and board shall not be a benefit of TLP services, per 10 CCR 2505-10 {8.75014}.
E. Items of personal need or comfort shall be paid out of money set aside from the member's income and accounted for in the determination of financial eligibility for the BI program.
F. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the Department.

8.7550.05 TLP Provider Agency Requirements

A. Policies
1. Members must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.
2. Members and Legally Authorized Representatives~~, families, medical proxies, or other substitute decision makers~~ shall be made aware of ~~accepting~~ the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.
3. Members must need available assistance in a congregate setting ~~milieu setting~~ for safety and supervision and require support in meeting psychosocial needs.
4. Members must require available paraprofessional nursing assistance on a 24-hour basis due to dependence in activities of daily living, locomotion, or cognition.
5. Understanding that members of transitional living programs frequently experience behavior which may be a danger to themselves or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other ~~members~~ residents or staff. The transitional living program must have written agreements with other providers in the community who may provide short term crisis intervention to provide a safe and secure environment for a member who is experiencing severe behavioral difficulties, or who is actively homicidal or suicidal.
6. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve members for whom they lack adequate resources to ensure safety of program members and staff.
7. Upon entry into the program, discharge planning shall begin with the member and family. Transitional living programs shall work with the member and case manager to develop a program of services and support which leads to the location of a permanent ~~setting~~ residence at the completion of transitional living program services.
8. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

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9. During daytime hours, the ratio of staff to members shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.
10. The duration of transitional living services shall not exceed six (6) months without additional approval, treatment plan review and re-authorization by the Department.

B. Training

1. At a minimum, the program director shall have an advanced degree in a health or human service-related profession plus three years of experience providing direct services to members ~~individuals~~ with a brain injury. A bachelor's degree with five (5) years of experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.
2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the member. These staff members will have successfully completed a training program of at least forty (40) hours duration.
3. TLP providers must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the TLP.
4. The provider, staff, and volunteers who provide direct member care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. TLPs certified prior to the effective date of these rules shall have sixty (60) days to satisfy this training requirement.
5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. TLPs certified prior to the effective date of these rules shall have sixty (60) days to satisfy this training requirement.
6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

8.7550.06 TLP Provider Reimbursement Requirements

A. Room and board shall not be a benefit of TLP services~~, per 10 CCR 2505-10 {8.745014}.~~.

B. TLP services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.

8.7551 Vehicle Modifications

8.7551.01 Vehicle Modifications Eligibility

A. Vehicle modifications is a service available to members enrolled in one of the following HCBS waivers:

1. Children's Extensive Support Waiver
2. Supported Living Services Waiver

8.7551.02 Vehicle Modifications Definition

A. Vehicle modifications means adaptations or alterations to an automobile ~~[or van]~~ that {are:}

1. ~~[is]~~ The member's primary means of transportation.
2. To accommodate the ~~[special]~~ needs of the member,{as a result of the member's disability and shall not be approved if the need is a typical age-related need.}
3. Are necessary to enable the member to integrate more fully into the community and to ensure the health and safety of the member.

8.7551.03 Vehicle Modifications Inclusions

A. Upkeep and maintenance of the modifications to the vehicle are allowable services.

8.7551.04 Vehicle Modifications Exclusions and Limitations

A. Items and services specifically excluded from reimbursement under the HCBS waivers include:

1. Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the member;
2. Purchase or lease of a vehicle; and
3. Typical and regularly scheduled upkeep and maintenance of a vehicle.

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8.7551.05 \Vehicle Modifications Case Management Agencies Responsibilities

A. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS waiver without an exception granted by the Department:
   1. The case manager may approve Vehicle Modifications when the total cumulative cost is under $10,000 for the cost of Home Modifications, Vehicle Modifications and Assistive Technology.\~~[The Case Manager may approve Vehicle Modification projects estimated at less the $10,000 for the total amount of Vehicle Modification, Home Modification and Assisitve Techfor the five (5) life of the waiver without prior authorization]~~
   2. \For modifications with a cumulative total over $10,000, the case manager shall obtain approval ~~to~~ {by} submitting a request to the Department.
      a. The case manager must obtain all supporting documentation according to department prescribed processes and procedures.
      b. An occupational or physical therapist (OT/PT) shall assess the member's needs and the therapeutic value of the requested Vehicle Modification. When an OT/PT with experience in Vehicle Modification is not available, a ~~[Department approved and]~~ qualified individual may be substituted, with Department approval.
      c. The case manager will obtain at least two bids for the necessary work. If the case manager has made three attempts to obtain a written bid from a provider and the provider has not responded within thirty (30) calendar days, the case manager may request approval of one bid.

B. Requests to exceed a member's cumulative allotment of $10,000 over the five-year life of the HCBS waiver\ ~~[this limitation]~~ \may be approved by the Department if it:
   1. Ensures the health and safety of the member;
   2. Enables the member to function with greater independence within the community ; or
   3. Decreases the need for paid assistance in another HCBS waiver service on a long-term basis.

C. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost effectiveness, prudent purchases and no unnecessary duplication.\

8.7551.06 \Vehicle Modifications Provider Agency Reimbursement

A. The total cost of Home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS waiver without an exception granted by the Department.

B. Vehicle Modifications that have been completed prior to approval will not be reimbursed.\

C. ~~[Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the member, to enable the member to function with greater independence in the home, or to decrease the need for paid assistance in another HCBS waiver service on a long-term basis.~~

D. ~~Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure Cost Effectiveness, prudent purchases and no unnecessary duplication.]~~

8.7552 Vision Services

8.7552.01 Vision Services Eligibility

A. Workplace Assistance is available to members enrolled in one of the following HCBS waivers:
   1. Developmental Disabilities Waiver
   2. Supported Living Services Waiver

8.7552.02 Vision Services Inclusions

A. HCBS Developmental Disabilities (DD) Waiver; Supported Living Services (SLS) Waiver
   1. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a member who is at least twenty-one (21) years of age.
   2. Lasik and other similar types of procedures are only allowable when:

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a. The procedure is necessary due to the member's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and
b. Prior authorized in accordance with Department procedures.

8.7553 Wellness Education Benefit [placeholder]

8.7554 {Wraparound Services}

8.7554.01 Wraparound Services Eligibility

A. Wraparound Services are services available to members enrolled in the HCBS Children's Habilitation Residential Program Waiver

8.7554.02 Wraparound Services Description and Definition

A. Wraparound services align strategies, interventions, and supports for the member and family, to prevent the need for out of home placement. This service may be utilized in maintaining stabilization, preventing crisis situations, and/or de-escalation of a crisis.
B. Wraparound services include Wraparound Plan and Prevention and Monitoring which are billed separately.
C. {A crisis means an event, series of events, and/or state of being that is more severe than typical for the child or youth and/or family; is outside the manageable range for the child or youth and/or their caregivers; and poses a danger to self, family, and/or the community.
D. A crisis may be self-identified, family identified, and/or identified by an outside party.
E. Wraparound Service may be provided individually, or in conjunction with the Child and Youth Mentorship service, defined at 8.7511}.

8.7554.03 CHRP Wraparound Plan

A. \The Wraparound Facilitator is responsible for the\ development of a Wraparound Plan with action steps to implement support strategies, prevent, and/or manage a future Crisis to include, but not limited to:
    1. The unique strengths, abilities, preferences, desires, needs, expectations, and goals of the member and family.
    2. Environmental modifications.
    3. Support needs in the family home.
    4. Respite services.
    5. Strategies to prevent crisis triggers.
    6. Strategies for Predictive and/or Increased Risk Factors.
    7. Learning new adaptive or life skills.
    8. Behavioral or other therapeutic interventions to further stabilize the member emotionally and behaviorally and to decrease the frequency and duration of any future behavioral crisis.
    9. Medication management and stabilization.
    10. Physical health.
    11. Identification of training needs and connection to training for family members, natural supports, and paid staff.
    12. Determination of criteria to achieve stabilization in the family home.
    13. Identification of how the plan will be phased out once the member has stabilized.
    14. Contingency plan for out of home placement.
    15. Wraparound Support Team may include ~~[Coordination among]~~ family caregivers, other family members, service providers, natural supports, professionals, and case managers required to implement the Wraparound Plan.
    16. Dissemination of the Wraparound Plan to all individuals involved in plan implementation.
B. Revision of strategies should be a continuous process by the Wraparound Support Team in collaboration with the member, until the member is stable and there is no longer a need for \Wraparound Support Services\ ~~[Intensive Support Services]~~.

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C. On-going ~~evaluation~~ monitoring after completion of the Wraparound Plan may be provided if there is a need to support the member and ~~[his or her]~~ {their} family in connecting to any additional resources needed to prevent a future crisis.

8.7554.04 Prevention and Monitoring

A. Follow-up services include ~~an evaluation~~ monitoring to ensure that triggers to the Crisis have been addressed in order to maintain stabilization and prevent a future Crisis.

B. ~~An evaluation~~ Monitoring of the Wraparound Plan should occur at a frequency determined by the member's needs and include at a minimum, visits to the member's home, review of documentation, and coordination with other Professionals and/or members of the Wraparound Support Team to determine progress.

C. Services include a review of the member's stability and monitoring of Increased Risk Factors that could indicate a repeat Crisis.

D. Revision of the Wraparound Plan should be completed as necessary to avert a Crisis or Crisis escalation.

E. Services include ensuring that follow-up appointments are made and kept.

8.7554.05 Wraparound Services Provider Agency Requirements

A. {Individuals providing Wraparound Services must meet the following criteria:

1. Wraparound Plan Facilitator must:

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

b. Has experience working with Long-Term Services and Supports (LTSS) populations, in a private or public social services agency may substitute for the required education on a year for year basis.

i. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

c. Have received certification through a Nationally Accredited Wraparound Program.

i. Training and certification must encompass all of the following:

a) Trauma informed care.
b) Youth mental health first aid.
c) Crisis support and planning.
d) Positive Behavior Supports, behavior intervention, and de-escalation techniques.
e) Cultural and linguistic competency.
f) Family and youth servicing systems.
g) Family engagement.
h) Child and adolescent development.
i) Accessing community resources and services.
j) Conflict resolution.
k) Intellectual and developmental disabilities.
l) Mental health topics and services.
m) Substance abuse topics and services.
n) Psychotropic medications.
o) Motivational interviewing.
p) Prevention, detection and reporting of mistreatment, abuse, neglect, and exploitation.

d. Complete re-certification in wraparound training at least every other year or as dictated by wraparound training program.}

8.7555 Workplace Assistance

8.7555.01 Workplace Service Eligibility

A. Workplace Assistance is available to members enrolled in one of the following HCBS waivers:

1. Developmental Disabilities Waiver

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2. Supported Living Services Waiver

8.7555.02 Workplace Service Definition

A. Workplace Assistance provides work-related supports for members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver that is above and beyond what could be regularly supported by the workplace supervisor, co-workers, or job coach, in order to maintain an individual job in an integrated work setting for which the member is compensated at or above minimum wage. Training/Job Coaching, accommodations, technology, and natural supports are to be used first to maximize the member's independence and minimize the need for the consistent presence of a paid caregiver, through Workplace Assistance. As such, the degree to which the member must be supported by a paid caregiver through the Workplace Assistance service, shall be based on the specific safety-related need(s) identified in the person-centered planning process for the member at their worksite.

8.7555.03 Workplace Service Inclusions

A. Workplace Assistance:
   1. Is provided on an individual basis, not within a group and cannot overlap with job coaching;
   2. Occurs at the member's place of employment, during the member's work hours, and when needed may also be used:
      a. Immediately before or after the member's employment hours; or
      b. during work-related events at other locations.
   3. Includes but is not limited to: promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs, redirecting, reminding to follow work-related protocols/strategies, and ensuring other identified needs are met so the member can be integrated and successful at work; and
   4. May include activities beyond job-related tasks that support integration at work, such as assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events.

B. Workplace Assistance is appropriate for and available to:
   1. Members who require Intensive Supervision or have a documented need which warrants a Rights Modification requiring extensive supervision, such as, a court order or the member meeting Public Safety Risk or Extreme Risk-to-Self criteria pursuant to {8.7002 (Member Rights} [~~Section 8.612.5(i)~~]).
   2. Members whose support team agrees there is justification for a paid caregiver to be present for a portion of the hours worked due to safety concerns; and those needs are beyond what could be addressed through natural supports, technology, or intermittent Job Coaching. The specific safety concerns identified by members and their support teams may include, but are not limited to:
      a. Regularly demonstrating behaviors that cause direct harm to themselves or others; or
      b. Intentionally or unintentionally putting themselves in unsafe situations frequently; or
      c. Often demonstrating poor safety awareness or making poor decisions related to personal safety.

8.7555.04 Workplace Service Access & Authorizations

A. Prior to Workplace Assistance being authorized, including at the Person-Centered Support Plan's annual renewal, the member and their support team shall determine that alternatives to paid caregiver supports were fully explored, by considering the factors listed below. Documentation of these considerations shall be reflected in the member's case management record.
   1. Job Coaching services have been or will be leveraged to promote the member's independence and minimize the need for the presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, promoting natural supports, integrating technology, and using systematic instruction techniques.
   2. The specific safety concern(s) to be addressed and how the Workplace Assistance staff could support the member in addressing the safety concerns while facilitating integration and independence at work.

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3. The nature of the job and work location, the member's longevity with the employer, the degree of continuity at the member's place of employment, and the likelihood of the member putting themselves/others in harm's way, despite training, technology, and cues from natural supports.
4. The member's desire to have a paid caregiver present for the identified time periods.
5. The Supported Employment provider's informed opinion regarding the need for paid caregiver support beyond intermittent Job Coaching. This opinion should be grounded in Employment First concepts as evidenced by:
    a. The provider's completion of a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification); or
    b. If the Supported Employment provider does not possess this credentialing, then the Supported Employment provider or the case manager may consult with:
        i. By someone who does possess either a Training Certificate or Certification
        ii. Or a representative from the Department who oversees the Workplace Assistance benefit.

8.7555.05 Workplace Service Exclusions and Limitations

A. A member's supervision level is not the sole factor which justifies the need for this service, therefore, the supervision level shall not be elevated in order to access the service. The member's supervision level at the worksite shall be based on actual need related to the member at work.

B. {The total number of units available for Workplace Assistance services in combination with other Supported Employment and day habilitation services, is seven thousand one hundred and twelve (7,112) units per support plan year. One (1) unit equals fifteen (15) minutes of service.}

8.7555.06 Workplace Service Provider Agency Requirements

A. Workplace Assistance staff shall consistently seek to promote the member's independence and integration at work. Where possible, efforts should be made to reduce or eliminate the need for Workplace Assistance services over time, and the efforts and progress shall be documented by the provider.

B. The training for Workplace Assistance staff should:
    1. Include fundamentals of Employment First principles with emphasis on promoting independence and inclusion; and
    2. Provide insight regarding a paid caregiver's role at a member's place of employment such that the Workplace Assistance staff's presence does not hinder the member's interaction with co-workers, customers, and other community members.

8.7556 Youth Day Service

8.7556.01 Youth Day Services Eligibility

A. Youth Day Service is a service available to members enrolled in the HCBS Children's Extensive Support Waiver.

8.7556.02 Youth Day Services Definition

A. Youth Day Service is the care and supervision of members ages twelve (12) through seventeen (17) while the primary caregiver works, volunteers, or seeks employment.

8.7556.03 Youth Day Services Inclusions

A. Youth ~~[day service]~~**{Day Service}** may be provided in the residence of the member, **{the}**youth day service provider, or in the community.

B. Youth ~~[day service]~~**{Day Service}** shall be provided according to an individual or group rate as defined below:
    1. Individual: the member receives youth day services with a staff ratio of 1:1, billed at a 15-minute unit. There are no other youth in the setting also receiving youth day service, respite or third-party supervision.
    2. Group: the member receives supervision in a group setting with other individuals who may or may not have a disability. Reimbursement is limited to the member.

8.7556.04 Youth Day Services Exclusions and Limitations

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A. This service is limited to members ages twelve (12) through seventeen (17).
B. This service may not substitute for or supplant special education and related services included in a member's Individualized Education Plan (IEP) developed under Part B of the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 (2011). This includes after school care provided through any education system and funded through any education system for any student.
C. This service may not be used to cover any portion of the cost of camp.
D. This service is limited to ten (10) hours per calendar day.

8.7557 State Funded Supported Living Services (State-SLS) Program

A. The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide ~~supports~~ services to individuals with an intellectual or developmental disability to remain in their community. The State-SLS program shall not supplant Home and Community-Based services for those who are currently eligible.

8.7557.01 State-SLS Definitions

~~[APPLICANT means an individual who is seeking supports from State-SLS program.~~
~~. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to section 25.5-10-209.5, C.R.S., has a valid provider participation agreement with the Department, and has a valid contract with the Department to provide these services.~~
~~A. CCB CASE MANAGER means the staff member of the Community Centered Board that works with individuals seeking services to develop and authorize services under the State-SLS program.~~
~~B. MEMBER means an individual who meets the DD Determination criteria and other State-SLS eligibility requirements and has been approved for and agreed to receive services in the State-SLS program.~~
~~C. MEMBER REPRESENTATIVE means a person who is designated by the member to act on the member's behalf. A member Representative may be: (A) a legal representative including, but not limited to a court appointed guardian, or a spouse; or (B) an individual, family member or friend selected by the member to speak for or act on the member's behalf.]~~

A. Corrective Action Plan means a written plan, which includes the detailed description of actions to be taken to correct non-compliance with State-SLS requirements, regulations, and direction from the Department, and includes the date by which each action shall be completed and the individuals responsible for implementing the action.

~~[COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that meets the requirements set forth in Section 25.5-10-209, C.R.S. and is responsible for conducting level of care evaluations and determinations for State-SLS services specific to individuals with intellectual and developmental disabilities.]~~

B. Community Resource means services and supports that a member may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to, services provided through private insurance, non-profit services and other government programs.

~~[COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the member.~~
~~Developmental Disability (DD) Determination means the determination of a Developmental Disability as defined in section 8.607.2~~
~~DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.~~
~~DEVELOPMENTAL DISABILITY means a disability that is defined in section 8.600.4.~~

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~~EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty one (21).~~
~~HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a member who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).~~
~~LONG TERM CARE SERVICES AND SUPPORTS (LTSS) means the services and supports utilized by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.~~
~~MEDICAID ELIGIBLE means an Applicant or member meets the criteria for Medicaid benefits based on a financial determination and disability determination.~~
~~MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses federal Medicaid statutory requirements concerning the operation of its Medicaid program.]~~

C. Natural Supports means an informal relationship that provides assistance and occurs in the member's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances
D. Performance and Quality Review means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by the Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements

~~[PLAN YEAR mean a twelve (12) month period starting from the date when State-SLS Supports and Services where authorized.~~
~~PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent.~~
~~PROGRAM APPROVED SERVICE AGENCY (PASA) means a developmental disabilities service agency or a service agency as defined in 8.602, that has received program approval, by the Department, to provide Medicaid Wavier services.~~
~~RELATIVE means a person related to the member by virtue of blood, marriage, or adoption.~~
~~RETROSPECTIVE REVIEW means the Department's review after services and supports are provided and the PASA is reimbursed for the service, to ensure the member received services according to the service plan and standards of economy, efficiency and quality of service.~~
~~STATE-SLS INDIVIDUAL SUPPORT PLAN means the written document that identifies an individual's need and specifies the State-SLS services being authorized, to assist a member to remain safely in the community.]~~

E. State Fiscal Year means a 12-month period beginning on July 1 of each year and ending June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in the calendar year.

~~[Services and Supports or Supports and Services means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided to~~
~~1. To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience person security and self-respect.~~
~~BB. SUPPORT SERVICE means the service(s) established in the State-SLS program that a CCB Case Manager may authorize to support an eligible member to complete the identified tasks identified in the member's Individualized Support Plan.~~
~~CC. WAIVER SERVICE means optional services and supports defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.]~~

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8.7557.02 State-SLS Administration

A. The ~~[CCB]~~ \Case Management Agency (CMA)\ shall administer the State\-Supported Living Services\ (SLS) program according to all applicable statutory, regulatory and contractual requirements, and Department policies and guidelines.

1. The ~~[CCB]~~ \CMA\ is responsible for providing case management to all individuals enrolled in the State-SLS program.
2. The ~~[CCB]~~ \CMA\ shall have written procedures related to the administration, case management, service provision, and waiting list for the State-SLS program.
3. All records must be maintained in accordance with {Section 8.7406}.
4. The ~~[CCB]~~ \CMA\ shall maintain a waiting list of eligible individuals for whom Department funding is unavailable in accordance with {section 8.7557~~6~~.8} [~~Section 8.501.7~~].
5. The ~~[CCB]~~ \CMA\ shall develop procedures for determining how and which individuals on the waiting list will be enrolled into the State-SLS program that comply with all applicable statutory, regulatory and contractual requirements including section {8.7557~~6~~.8} [~~8.501.7~~].
6. Any decision to modify, reduce or deny services or supports set forth in the State-SLS program, without the Individual's or Legally Authorized Representative's agreement, are subject to the requirements in {Section 8.7206.19} [~~Section 8.605.~~]

B. Member Eligibility

1. General Eligibility requirements
   a. Individuals must be a resident of Colorado;
   b. Be eighteen (18) years of age or older; and
   c. Be determined to have an intellectual or developmental disability pursuant to the procedures set forth in {8.7206.4} [~~section 8.607.2.~~]
2. Eligibility for the State-SLS program does not guarantee the availability of services ~~[and supports]~~ under this program.

C. General Provisions

1. The availability of services offered through the State-SLS program may not be consistent throughout the State of Colorado or between ~~[CCB]~~ \CMA\.
2. An individual enrolled in the State-SLS program shall access all benefits available under the Medicaid State Plan, HCBS Waiver or EPSDT, if available, prior to accessing services under the State-SLS program. Services through the State-SLS program may not duplicate services provided through the State Plan when available to the member.
3. Evidence of attempts to utilize all other public benefits and available and accessible community resources must be documented in the State-SLS individualized Support Plan by the ~~[CCB]~~ case manager, prior to accessing State-SLS services or funds.
4. The State-SLS program shall be subject to annual appropriations by the Colorado General Assembly.
5. These regulations shall not be construed to prohibit or limit services and supports available to persons with intellectual and developmental disabilities that are authorized by other state or federal laws.
6. When an individual is enrolled only in the State-SLS program the ~~[CCB]~~ case manager shall authorize a provider agency to deliver the services, when available.
7. ~~When a [PASA] \provider agency\ is not available the [CCB] case manager may authorize and provide the service, through the State-SLS program, to assist the member with tasks identified in his or her Individual Support Plan.~~
8. The ~~[CCB]~~ Case Manager may authorize services ~~[and Supports]~~ from multiple State-SLS service categories at once, unless otherwise stated.
9. Unless otherwise specified, State-SLS services ~~[and Supports]~~ may be utilized in combination with other community resources and/or Medicaid services ~~[and supports]~~, as long as they are not duplicative, and all other available and accessible resources are utilized first.

D. Performance and Quality Review

1. The Department shall conduct a Performance and Quality Review of the State-SLS program to ensure that the ~~[CCB]~~ \CMA\ is in compliance with all statutory and regulatory requirements.

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2. A ~~[CCB]~~ \CMA\found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but is not limited to:
    a. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;
    b. A detailed timeframe for completing the actions to be taken;
    c. The employee(s) responsible for implementing the actions; and
    d. The estimated date of completion.
3. The ~~[CCB]~~ \CMA\shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The ~~[CCB]~~ \CMA\shall explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.
    a. Upon receipt of the proposed Corrective Action Plan, the Department will notify the ~~[CCB]~~ \CMA\in writing whether the Corrective Action Plan has been accepted, modified, or rejected.
    b. In the event that the Corrective Action Plan is rejected, the ~~[CCB]~~ \CMA\shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.
    c. The ~~[CCB]~~ \CMA\shall begin implementing the Corrective Action Plan upon acceptance by the Department.
    d. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.7557.03 State-SLS Inclusions and Covered Services [~~and Supports~~]

A. ~~[Supports]~~ \Services\ for individuals waiting for HCBS waiver enrollment.
    1. Eligible members may receive the following services ~~[and Supports.]~~
        a. All HCBS waiver services ~~[and Supports]~~ identified as available to members enrolled in the SLS waiver as identified throughout section 8.87500.
        b. Service limitations in the HCBS SLS waiver and set forth in section 8.7500 and 8.7400 apply to the State-SLS program.
        c. When a provider agency is not available to provide services ~~[and Supports]~~ the ~~[CCB]~~ \CMA\ may authorize the ~~[Support Services, to provide the needed Supports and Services]~~ \services\ identified in the State-SLS Individual Support Plan.

B. ~~[Supports]~~ \Services\ for Individuals Experiencing Temporary Hardships
    1. State-SLS may be utilized to provide the following temporary ~~[Supports and]~~ services to individuals who have been determined to meet the criteria for an Intellectual / Developmental Disability as specified in Section {8.7206.4} ~~[8.607.2]~~, in situations where temporary assistance can alleviate the need for a higher level of care. These services ~~[and Supports]~~ cannot be duplicative and shall not be accessed if available through other sources. In order to access State-SLS, an Individual Support Plan must be completed.
        a. Payment of utilities:
            i. Paying gas/electric bills and/or water/sewer bills:
                i. Documentation must be maintained by the ~~[CCB]~~ \CMA\that all alternative programs, community support, and natural supports were utilized before any State-SLS funds were authorized.
            ii. ~~[Supports]~~ \Services\ with acquiring emergency food, at a retail grocery store when there are no other community resources available
                a. Documentation must be maintained by the ~~[CCB]~~ \CMA\demonstrating the reason why State-SLS funds were utilized over other sources of emergency food. This may include but is not limited to:
                    i. Other emergency food programs are not available.
                    ii. Home delivered meals have unexpectedly stopped.
            iii. Pest infestation abatement:

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a. Documentation must be maintained by the case manager showing that infestation abatement is not covered under the member's residential agreement or lease.
b. Documentation that the pest abatement professional is licensed in the state of Colorado, must be maintained by the ~~[CCB]~~ \CMA\and provided to the Department upon request.
c. Pest infestation abatement shall not be authorized if the member resides in a provider owned and/or controlled property.
d. Documentation showing proof of payment must be maintained by the ~~[CCB]~~ \CMA\ administering the State-SLS program;

2. Service Limitations
   i. Support for utilities shall not exceed $1,000.00 in a State Fiscal Year.
   ii. Support for pest infestation abatement shall not exceed $2,000.00 in a State Fiscal Year.
      a. Supports for pest infestation abatement shall not cover more than one infestation event in a State Fiscal Year; and
      b. Multiple treatments per event may be authorized, if determined necessary by a licensed pest abatement professional.
   iii. Emergency food support shall not exceed $400.00 in a State Fiscal Year.

C. \Services\ to Support~~[ing]~~ Independence in the Community.
1. State-SLS may be utilized to provide an individual found eligible for or enrolled in an HCBS Medicaid waiver, with a one-time payment or acquisition of needed household items, in the event the member is moving into a residence as defined in {8.7105.9.A.5} [Section 8.500.93.A.(7)].
   a. State-SLS funds may be utilized for payment or acquisition of:
      i. Initial housing costs including but not limited to a one-time initial set up for pantry items and/or kitchen supplies and/or furniture purchase.
   b. Individuals enrolled in the HCBS-DD waiver residing in a Group Residential Supports and Services (GRSS) or Individual Residential Supports and Services - Host Home (IRSS-HH) setting are not eligible for this Support.
2. State-SLS funds may support someone to have greater independence when they are moving into their own home, by paying for housing application fees.
3. The ~~[CCB]~~ \CMA\shall maintain receipts or paid invoices for purchases authorized in this section. Receipts or paid invoices must contain at a minimum, the following information: business name, item(s) purchased, item(s) cost, date paid, and description of items purchased. Documentation must be made available to the Department upon request. All items must be purchased from an established retailer that has a valid business license.
4. Service limitations
   a. The one-time furniture purchase shall not exceed $300.00.
   b. The one-time initial pantry set up shall not exceed $100.00.
   c. The one-time purchase of kitchen supplies shall not exceed $200.00.
   d. The payment of housing application fees are limited to five (5) in a State Fiscal Year.

D. On-going State-SLS Support.
1. State-SLS funds may be authorized by the ~~[CCB]~~ \CMA\for individuals who have been determined to meet the DD Determination requirements, but do not meet the requirements to be enrolled in HCBS-SLS Waiver section {8.7105.9} ~~[8.500.93]~~.
   a. A member may be authorized to receive waiver services where the HCBS-SLS waiver is eligible in sections {8.7502-8.7556~~7~~} ~~[8.500.90]~~.
   b. Service limitations and service rules found in the HCBS-SLS eligible waiver services at section~~s~~ {8.7500} [8.500.90] apply to the State-SLS program.
   c. A provider agency is authorized to provide State-SLS services; and
2. When an individual is enrolled in an HCBS waiver, {the individual may receive services through the State SLS program, as long as the services are not duplicative.} ~~[other than~~

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~~the HCBS DD or HCBS SLS waiver and needed services and Supports not provided by that waiver, the CCB CMA may authorize State SLS funds.]~~

a. [~~A comparable service must not be available in the enrolled waiver~~]. {Individuals enrolled in HCBS SLS and HBCS DD shall not use State SLS for ongoing services but may use State SLS for emergency services only.}
b. State-SLS funds may not be utilized for Home {Modification} ~~[Accessible Adaptation]~~, or Vehicle Modification.
c. Only a provider agency can provide these services.

3. Service Limitation
   a. Total authorization limit for the plan year shall be determined by the Department and be communicated annually on the State-SLS Program rate schedule.

8.7557.04 State-SLS Individual Support Plan

A. State-SLS members are required to have a State SLS Individual Support Plan that is signed and authorized by the ~~[CCB]~~ \CMA\case manager and the member, or their Legally Authorized Representative.

B. The State-SLS Individual Support Plan shall be developed through an in-person face to face meeting that includes at least, the individual seeking services and the ~~[CCB]~~ case manager. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or member (e.g. natural disaster, pandemic, etc.

C. If a member seeks additional ~~[supports]~~ \services\ or ~~[alleges]~~ \identifies\ a change in need, the State-SLS Individual Support Plan shall be reviewed and updated by the ~~[CCB]~~ case manager prior to any change in authorized services ~~[and supports]~~.

D. The State-SLS Individual Support Plan shall be effective for no more than one year and reviewed at least every 6 months, in a face-to-face meeting with the member or on a more frequent basis if a change in need occurs. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or member (e.g. natural disaster, pandemic, etc.)
   1. Any changes to the provision of the services ~~[and supports]~~ identified in the State-SLS Individual Support Plan are subject to available funds within the defined service area.
   2. Any decision to modify, reduce or deny services ~~[and supports]~~ set forth in the State-SLS Individual Support Plan, without the member's consent is subject to the Dispute Resolution Process found in section {Section 8.7206.19}~~[8.605.2.]~~

E. The State-SLS Individual Support Plan and all supporting documentation will be maintained by the case manager and will be made available to the Department upon request.

F. The State-SLS Individual Support Plan shall include the following:
   1. The services ~~[and supports]~~ authorized, the member's identified needs and how the services ~~[and supports]~~ will address the needs.
   2. The scope, frequency, [and] duration \and cost\ of each service.
   3. ~~[Total amount needed to support the individual and what]~~ Other community resources ~~[are contributing].~~ \being utilized\

~~[Additional information to be included for authorization of services On-going State -SLS Supports;]~~

   4. Documentation demonstrating why the individual enrolled in State-SLS is not eligible or enrolled in a HCBS Medicaid waiver or documentation showing which HCBS -waiver the individual is enrolled in; ~~and~~
   5. ~~[Documentation demonstrating how authorized services are not duplicative or comparable to others the individual is eligible for or has access to.]~~
   6. Documentation demonstrating if other public or community resources have been utilized and why State-SLS funds are being utilized instead of or in combination with other resources.
   7. Total cost of the \services\ ~~[supports]~~ being authorized.
   8. Information to support authorization of services ~~under~~ \~~Services~~\ for Individuals Experiencing Temporary Hardships, including:

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a. A description of the hardship.
b. The reason for the hardship.
c. The length of time the support will be authorized, including the date of the onset of the hardship and the date it is expected to end.
d. Total amount needed to support the individual and what other community resources are contributing.
e. A plan to reasonably ensure the hardship is temporary.
f. A plan to reasonably ensure that dependence on State-SLS funds will be temporary.
g. The dates of when the long-term solution will be in place and when the temporary hardship is expected to end.
h. Documentation demonstrating how utilizing State-SLS funds will lead to the member gaining more independence in the community or maintaining their independence in the community

~~[Additional information required for authorization of services for the purpose of Supporting Independence in the Community:~~

i. ~~Total amount needed to support the individual and what other community resources are contributing.~~

~~Additional information to be included for authorization of services On-going State-SLS Supports;~~

ii. ~~Documentation demonstrating why the individual enrolled in State-SLS is not eligible or enrolled in a HCBS Medicaid waiver or documentation showing which HCBS waiver the individual is enrolled in; and~~
iii. ~~Documentation demonstrating how authorized services are not duplicative or comparable to others the individual is eligible for or has access to.]~~

8.7557.05 State-SLS Case Management Services

A. Administration
1. ~~[CMAs]~~ \The CMA\ shall comply with all requirements set forth {throughout} ~~in~~ section {8.7200}. ~~[8.607.1.]~~

B. Case Management Duties:
1. The case manager shall coordinate, authorize and monitor services based on the approved State-SLS Individual Support Plan.
   a. The case manager shall have, based on the member's preference, a face to face or telephone contact once per quarter with the member.
2. The ~~[CCB]~~ case manager shall assist members to gain access to other resources for which they are eligible and to ensure members secure long-term support as efficiently as possible.
3. The ~~[CCB]~~ case manager shall provide all State-SLS documentation upon the request from the Department.
4. Referrals to the State-SLS program shall be made through the ~~[CCB]~~ \CMA\ in the geographic defined service area the member or Applicant resides in.

8.7557.06 State-SLS Transferring Services Between \Case Management Agencies\ ~~[Community Centered Boards]~~:

C. When an individual enrolled in, or on the waiting list for, the State-SLS program moves to another ~~[CCB]~~ \Case Management Agency's\ defined service area, and wishes to transfer their State-SLS, the following procedure shall be followed:
1. The originating ~~[CCB]~~ \CMA\ will contact the receiving ~~[CCB]~~ \CMA\to inform them of the individual's desire to transfer.
2. The originating ~~[CCB]~~ \CMA\will send the State-SLS Individual Support Plan to the receiving ~~[CCB]~~ \CMA\, where the receiving ~~[CCB]~~ \CMA\will determine if appropriate State-SLS funding is available or if the individual will need to be placed on a waiting list. The receiving ~~[CCB]~~ \CMA's\ decision of service availability will be communicated in the following way:

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a. The receiving ~~[CCB]~~ \CMA\will notify the individual seeking transfer of its decision by the individual's preferred method, no later than ten (10) business days from the date of the request; and
b. The receiving ~~[CCB]~~ \CMA\will notify the originating ~~[CCB]~~ \CMA\of its decision by U.S. Mail, phone call or email of its decision no later than ten (10) business days from the date of the request.

3. The decision shall clearly state the outcome of the decision including:
   a. The basis of the decision; and
   b. The contact information of the assigned Case Manager or waiting list manager.
4. The originating ~~[CCB]~~ \CMA\shall contact the individual requesting the transfer no more than five (5) days from the date the decision was received to:
   a. Ensure the individual understands the decision; and
   b. Support the individual in making a final decision about the transfer.
5. If the transfer is approved, there shall be a transfer meeting in-person when possible, or by phone if geographic location or time does not permit, within fifteen (15) business days of when the notification of service determination is sent out by the receiving ~~[CCB]~~ \CMA\. The transfer meeting must include but is not limited to the transferring individual and the receiving case manager. Any additional attendees must be approved by the transferring individual.
6. The receiving ~~[CCB]~~ \CMA\ must ensure that:
   a. the transferring individual meets his or her primary contact of the receiving ~~[CCB]~~ \CMA\.
   b. The individual is informed of the date when services ~~[and Supports]~~ will be transferred, when services ~~[and Supports]~~ will be available, and the length of time the ~~[Supports and]~~ services will be available.
7. The receiving ~~[CCB]~~ case manager shall have an in-person face to face meeting with the member to review and update the State-SLS Individual Support Plan, prior to the ~~[Supports and]~~ services being authorized. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or member (e.g. natural disaster, pandemic, etc.).

8.7557.07 State-SLS Waiting List Protocol

D. Persons determined eligible to receive services under the State SLS program, shall be eligible for placement on a waiting list for services when state funding is unavailable.
E. Waiting lists for persons eligible for the State SLS program shall be administered by the CMA, uniformly administered throughout the State and in accordance with these rules and the Department's procedures.
F. Persons determined eligible shall be placed on the waiting list for services in the CMA service area of residency.
   1. The date used to establish a person's placement on a waiting list shall be:
      a. The date on which an individual is determined eligible for the State-SLS program through the DD Determination and the identification of need.
G. As funding becomes available in the State SLS program in a defined service area, persons shall be considered for services in order of placement on the local CMA's waiting list.
H. Individuals with no other State or Medicaid funded services or supports will be given priority for enrollment including individuals who lose Medicaid eligibility and lose Medicaid Waiver services.
I. Exceptions to these requirements shall be limited to:
   1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered, and the emergency cannot be resolved in another way. Emergencies are defined as follows:
      a. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; whose primary residence during the night is a public or private facility that provides temporary living accommodations; any other unstable or

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non-permanent situation; is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

b. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

c. Danger to Others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by them. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

d. Danger to Self: a person's medical, psychiatric or behavioral challenges are such that they are seriously injuring/harming themself or is an imminent danger of doing so.

e. Loss or Incapacitation of Primary Caregiver: a person's primary caregiver is no longer in the person's primary residence to provide care; the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; the primary caregiver is age 65 years or older and continuing to provide care poses an imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.

J. Documentation demonstrating how the individual meets the emergency criteria shall be kept on file at the ~~[CCB]~~ \CMA\ and made available to the Department upon request.

8.7557.08 State-SLS Case Management Agency and Provider Agency Reimbursement

A. A ~~[PASA]~~ \provider agency\ must submit all claims, payment requests, and/or invoices to the ~~[CCB]~~ \CMA\ for payment within thirty (30) days of the date of service, except for Services and Supports rendered in June, the last month of the State Fiscal Year. All claims, payment requests, and/or invoices for services rendered in June must be submitted by the date specified by the ~~[CCB]~~ \CMA\to ensure payment.

C. ~~[CCB]~~ \CMA\must submit all claims, payment requests, and/or invoices in the format and timeframe established by the Department.

D. ~~[CCB]~~ \CMA\and provider agency claims, payment requests, or invoices for reimbursement shall be made only when the following conditions are met:

1. Services ~~[and Supports]~~ are provided by a qualified provider agency.
2. Services ~~[and Supports]~~ are authorized and delivered in accordance with the frequency, amount, scope and duration of the service as identified in the member's State-SLS Individual Support Plan;
3. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the State-SLS Individual Support Plan and in accordance with the service definition;
4. All case management activities must be documented and maintained by the ~~[CCB]~~ \CMA\.

E. ~~[CCB]~~ \CMA\and provider agencies shall maintain records in accordance with Section 8.130.2 {and 8.7406}.

F. ~~[CCB]~~ \CMA and provider agency\ reimbursement shall be subject to review by the Department and may be completed after the payment has been made to the CMA and provider agency. ~~[CCB]~~ \CMAs and provider agencies\ are subject to all program integrity requirements in accordance with section 8.076.

G. The reimbursement for this service shall be established in the Department's published fee schedule.

H. Except where otherwise noted, provider agency reimbursement shall be based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private provider agencies and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin and can be accessed through the Department's fiscal agent's website.

1. State-SLS rates shall be set and published in the provider bulletin annually each State Fiscal Year.

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8.7558 Family Support Services Program (FSSP)

FSSP Administration

A. The ~~[Community Centered Board (CCB)]~~ \Case Management Agency (CMA)\ shall administer the Family Support Services Program (FSSP), subject to available appropriations and according to the rules, regulations, policies and guidelines of the Department, local Family Support Council (FSC) and CMA.
B. The \CMA\ shall ensure that the FSSP is implemented within its defined service area.
C. The \CMA\ shall designate one (1) person as the contact for the overall implementation and coordination of the FSSP.
D. Referrals to the FSSP shall be made through the \CMA\ pursuant to {Section 8.7206.2} ~~[Section 8.607.]~~
E. Nothing in these rules and regulations shall be construed as to prohibit or limit services and supports available to an member with an Intellectual and Developmental Disability (IDD) or Developmental Delay and their families which are authorized by other state or federal laws.
F. The \CMA\, in cooperation with the local FSC, shall ensure that the FSSP is publicized within the designated service area.
G. The \CMA\ shall develop written policies and procedures for the implementation and ongoing operation of the FSSP, which must be kept on file and made available to the Department or the public, upon request.

FSSP Family Support Council (FSC)

A. The \CMA\ shall assist its defined service area to establish and maintain an FSC pursuant to Section 25.5-10-304, C.R.S.
B. The \CMA\ shall establish an FSC roster that includes the names of members, type of membership and identifies the chairperson. The roster shall be available to the Department or the public, upon request.
C. Composition of the FSC:
    1. The majority of the members and the chairperson of each FSC shall be family members of an individual with an ~~[Intellectual and Developmental Disability (]~~IDD~~[)]~~ or Developmental Delay.
    2. New members of the FSC shall be recruited from the service area. New members shall be approved by the current FSC and the ~~[of directors]~~ {governing body} of the \CMA\.
    3. The members of the FSC shall receive written notice of their appointment.
    4. The \CMA\ shall ensure an orientation and necessary training regarding the duties and responsibilities of the FSC is available for all council members. The training and orientation shall be documented with a record of the date of the training, who provided the training, training topic, and names of attendees.
    5. The size of the FSC shall be sufficient to meet the intent and functions of the council, but no fewer than five (5) persons, unless approved by the Department.
    6. Each FSC shall establish the criteria for tenure of members, selection of new members, the structure of the council and, in conjunction with the \CMA\, a process for addressing disputes or disagreements between the FSC and the \CMA\. Such processes shall be documented in writing. Processes may include a request for mediation assistance from the Department.
D. The FSC duties include providing guidance and assistance to the \CMA\ on the following:
    1. Overall implementation of the FSSP;
    2. Development of the written annual FSSP report for the defined service area, as defined at {8.75587.12} ~~[Section 8.613.M]~~;
    3. Development of written procedures describing how families are prioritized for FSSP funding;
    4. Development of written policy defining how an emergency fund is established, funded and implemented. The policy must include a definition of a short-term crisis or emergency and the maximum amount of funds a family may receive per event and/or year;

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5. Provide recommendations on defining the "other" service category within the parameters as defined in this part;
6. Monitor the implementation of the overall services provided in the defined service area; and
7. Provide recommendations on how to assist families who are transitioning out of the FSSP.

FSSP Member Eligibility

A. Any individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay, as determined pursuant to Section 25.5-10-211, C.R.S., living with their family is eligible for the FSSP. Living with a family means that the individual's place of residence is with that family.
   1. Living with family may include periods of time from one (1) day to up to six (6) months during which time the individual is not in his or her primary residence because of transition into or out of the home.
   2. The \CMA\, in cooperation with the local FSC, shall determine what constitutes a transition.

B. The family and eligible individual shall reside in the State of Colorado.

C. ~~All eligible individuals 18 and older must provide proof of lawful presence in the United States to receive FSSP funding.~~

D. Eligibility for the FSSP does not guarantee the availability of services ~~or supports~~ under this program.

FSSP Direct Services and Inclusions

A. Services and supports available under the FSSP may be purchased from a variety of providers who are able to meet the individual needs of the family.

B. All services must be needed as a result of the individual's IDD or Developmental Delay and shall not be approved if the need is a typical age-related need. Correlation between the need and the disability must be documented in the Family Support Plan (FSP).

C. All services must be provided in the most cost-effective manner, meaning the least expensive manner to meet the need.

D. All services shall be authorized pursuant to the FSP.

E. Services provided to the family through the FSSP shall not supplant third party funding sources available to the family including, but not limited to, public funding, insurance, or trust funds.

F. \CMA\s shall not charge a separate fee for assisting individuals to access services identified on the FSP.

G. FSSP funds shall not be used for any donation to religious, political, or otherwise causes, or activities prohibited by law.

H. Included Direct Services:
   1. Assistive technology is equipment or upgrades to equipment, which are necessary for the individual with an IDD or Developmental Delay to communicate through expressive and receptive communication, move through or manipulate his or her environment, control his or her environment, or remain safe in the family home.\Assistive technology includes non-adaptive equipment that meets disability-specific needs identified in the Family Support Plan.\
   2. Environmental engineering is a home or vehicle modification needed due to the individual's disability and is not a regular maintenance or modification needed by all owners. Modifications to the home or vehicle must be:
      a. Necessary due to the individual's IDD or Developmental Delay;
      b. Needed due to health and safety; or
      c. To allow the individual to attain more independence;
   3. Modifications must be completed in a cost-effective manner. Cost-effective manner means the least expensive manner to meet the identified need. Home modifications are to be limited to the common areas of the home the individual with an IDD frequents, the individual's bedroom, and one bathroom. Other bedrooms and bathrooms shall not be modified. All devices and adaptations must be provided in accordance with applicable state or local building codes and/or applicable standards of manufacturing, design, and installation. Only homes or vehicles occupied and owned by the family where the eligible

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individual resides may be modified. Minor modifications may be made to rental units with the permission of the landlord. Rental modifications must be made in a way that the modification can be moved with the eligible individual during a change in residence.

4. Medical and dental items prescribed by a licensed medical professional qualified to prescribe such items and are needed to maintain or attain physical health. Medical, dental, and vision services, exams and procedures are available when not covered by another source.
    a. Over the counter medications and vitamins are excluded, except as indicated at Section 8.800.4.D, when prescribed by a licensed medical professional qualified to write such prescriptions.
5. Other: Services in this category must be identified in the FSP, are specific to the family, and are limited to:
    a. A consultant and/or advocate to assist a family with accessing services outside of the \CMA\.
    b. Recreational needs of the individual with an IDD or Developmental Delay when the need of recreation is above and beyond the typical need due to the disability or delay. The cost of family recreation passes shall be [~~limited to $650 or~~] \the cost of\ one family pass[~~, whichever is less~~,] per fiscal year and shall be limited to use only at community recreation centers, \except in communities where community recreation centers do not exist and in cases where the use of an alternative recreation facility is justified by a need related to the disability or delay, and the activity and/or facility is recommended by a licensed or certified professional qualified to make the recommendation. In such circumstances, the CMA shall document the professional recommendation and demonstrate that the chosen facility is the least expensive option to meet the family's needs.\
        i. The following items are specifically excluded under the FSSP and shall not be eligible for coverage:
            a) \Entrance fees for:
                1. Zoos;
                2. Museums;
                3. ~~Butterfly Pavilion;~~
                4. Movie theaters, performance theaters, concerts, other entertainment venues; and
                5. Professional and minor league sporting events.
            b) Outdoors play structures; and
            c) Batteries for recreational items.\; [~~and,~~
            d) ~~Passes for Family admission to recreation centers.]~~
    c. Specialized services as identified by the FSC and \CMA\ included in their written policy and are available to any family receiving ongoing FSSP assistance in the service area.
    d. Parent and sibling support, which may include special resource materials or publications, cost of care for siblings, or behavioral services or counseling.
    e. Professional services are services which require licensure or certification to treat a human condition other than medical, dental or vision, and is provided to the individual with an IDD or Developmental Delay. Professional services must be provided by qualified, certified and/or licensed personnel in accordance with the standards and practices of the industry. Professional services may include related support items\, equipment,\ or activities which are recommended as part of the therapy with supporting documentation from the treating professional. Insurance expenses directly incurred by the individual with an IDD or Developmental Delay are included.
    f. \Respite is the temporary care of an individual with an IDD that provides relief to the primary caregiver~~family~~.\
    g. Program expenses are services related to serving multiple families and are funded through the direct service line.

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6. This service is not identified in the individual's FSP. This service is provided by the \CMA\ for the benefit of multiple families.
7. Program expenses are the maintenance, operation, or enhancement of a resource library that consists of an inventory of goods and equipment used to meet the needs of individuals with an IDD or Developmental Delay on a temporary basis.
8. Program expenses are the costs associated with participation with other community agencies in the development, maintenance, and operation of projects, supports or services that benefit individuals with an IDD or Developmental Delay.
9. Program expenses are the development or coordination of a training event for families.
10. Program expenses are the costs of an event sponsored by the \CMA\ for all eligible individuals and their families to meet other families to provide socialization and an opportunity to build a network of support.
11. Program expenses are the development and coordination of group respite.
12. The FSC in conjunction with the \CMA\ shall determine the maximum amount of direct services to be used for program expenses.
    a. Respite is the temporary care of an individual with an IDD that provides relief to the family.
    b. Transportation is the direct cost to the family that is higher than costs typically incurred by other families because of specialty medical appointments or therapies. Specialty medical appointments or therapies are defined as appointments needed due to the individual's IDD or Developmental Delay. The direct cost is the cost of transportation, lodging, food expense, and long-distance telephone calls to arrange for or coordinate medical services which are not covered by other sources.

FSSP Waiting List

A. The \CMA\ shall maintain an accurate and up-to-date waiting list of eligible individuals for whom ~~Department~~ \FSSP\ funding is unavailable in the current fiscal year.
B. In cooperation with the local FSC, the \CMA\ shall develop written procedures for determining how and which individuals on the waiting list will be enrolled into the FSSP.
C. Individuals receiving ongoing FSSP funding shall not be listed on the waiting list for the program.
D. Individuals determined to be prioritized for FSSP funding shall be served prior to individuals determined at a lower level of prioritization.
E. The \CMA\ must inform eligible families of the program and waiting list procedures and offer assessment and enrollment onto either the waiting list or the program, based on the assessment and available appropriations.
F. Any individual on the waiting list for FSSP may receive emergency funding through the \CMA\ through the FSSP, if the needs meet the parameters set by the FSC and the \CMA\.
G. Waiting lists shall not exist for any \CMA\ that does not expend all FSSP direct service funds.

FSSP Prioritization for Family Support Services (FSSP) Funding

A. \CMA\s must ensure that families with the highest assessed needs shall be prioritized for FSSP state funding.
B. \CMA\s, in conjunction with the FSC, will develop written procedures that describe how families shall be prioritized and notified of the prioritization process.
C. The assessment process shall be applied equally and consistently to all families who are assessed.
D. \CMA\s must distribute the prioritization process to families in their defined service area at the time the family requests FSSP funding, when the individual is placed on the waiting list, or upon request.
E. The \CMA\ must notify families in writing of the results of the assessment.
F. All families, both on the waiting list and receiving FSSP services, shall be assessed for level of need on an annual basis or earlier if the family's circumstances change.
G. The assessment must contain the following components:
    1. The qualifying individual's disability and overall care need, which includes:
        a. The type of disability or condition and the need and complexity of medical or personal care for the individual;

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b. The need for, frequency of, and amount of direct assistance required to care for the individual; and
c. The types of services needed that are above and beyond what is typically needed for any individual.

2. The qualifying individual's behavioral concerns, including how behaviors disrupt or impact the family's daily life, the level of supervision required to keep the individual and others safe, and the services and frequency required to help with the behaviors.
3. The family composition, which considers obligations and limitations of the parent(s), the number of siblings, disabilities of other family members living in the home, and the level of stability of the family, such as pending divorce or age and disability of parents.
4. The family's access to support networks, which includes the level of isolation or lack of support networks for the family, such as not having extended family nearby, living in rural areas or availability of providers.
5. The family's access to resources such as family income, insurance coverage, HCBS waivers, and/or other private or public benefits.

FSSP Case Management Responsibilities

A. Case management is the coordination of services provided for individuals with an IDD or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education, and other services to ensure non-duplication of services, and monitor the effective and efficient provision of services across multiple funding sources.
B. At minimum, the case manager is responsible for:
   1. Determining initial and ongoing eligibility for the FSSP;
   2. Development, application assistance, and annual re-evaluation of the Family Support Plan (FSP); and
   3. Ensuring service delivery in accordance with the FSP.
C. Family Support Plan Requirements
   1. Families enrolled into the FSSP shall have an individualized FSP which meets the requirements of an Individualized Plan, as defined in Sections 25.5-10-202 and 25.5-10-211, C.R.S., and includes the following information:
      a. The name of the eligible individual;
      b. The names of family members living in the household;
      c. The date the FSP was developed or revised;
      d. The prioritized needs requiring support as identified by the family;
      e. The specific type of service or support, how it relates to the family need and the individual's disability or developmental delay, and period which is being committed to in the FSP, including, when applicable, the maximum amount of funds which can be spent for each service or support without amending the FSP;
      f. Documentation regarding cost-effectiveness of a service or support, which can include quotes, bids, or product comparisons but must include the reason for selecting a less cost-effective service or support, when applicable;
      g. A description of the desired results, including who is responsible for completion;
      h. The projected timelines for obtaining the service or support and, as appropriate, the frequency;
      i. A statement of agreement with the plan;
      j. Signatures, which may include digital signatures of a family representative and an authorized \CMA\ representative;
      k. The level of need;
      l. The length of time the funds are available; and
      m. A description of how payment for the services or supports will be made.
   2. The FSP shall integrate with other service plans affecting the family and avoid, where possible, any unnecessary duplication of services and supports.
   3. The FSP shall be reviewed at least annually or on a more frequent basis if the plan is no longer reflective of the family's needs.

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a. Any changes to the provision of services and supports identified in the FSP are subject to available funds within the defined service area.
b. Any decision to modify, reduce or deny services or supports set forth in the FSP, without the family's agreement, are subject to the requirements in {Section 8.7206.19} ~~[Section 8.605]~~.

~~Management and General Activities~~
~~Management of and general activities of FSSP are the financial and corporate administration responsibility of the \CMA\ specific to FSSP requirements by the Department.]~~

D. Emergency Fund
1. Each \CMA\ shall establish an emergency fund that may be accessed by any individual eligible for the FSSP when needed due to an unexpected event that has a significant impact on the individual or family's health or safety and impacts the family's daily activities.
2. Any individual with an IDD or Developmental Delay determined by the \CMA\ and living with family shall be eligible to receive emergency funds regardless of the enrollment status of the family.
3. The \CMA\ in conjunction with the Family Support Council shall develop written policies and procedures regarding the Emergency Fund. At a minimum the policies and procedures must:
a. Define the purpose of the emergency fund;
b. Define an unexpected event and significant impact;
c. Describe the process for accessing emergency funds;
d. Describe how funding determinations are made;
e. Give a timeline of the determination of the request;
f. Define the maximum funding amount per family or per event; and
g. Describe how families will be notified of the decision in writing.

FSSP Billing and Payment Procedures

A. The \CMA\ shall develop and implement policies, procedures, and practices for maintaining documentation for the FSSP and reporting information in the format and timeframe established by the Department.
B. Families shall maintain and provide either receipts or invoices to the \CMA\ documenting how funds provided to the family through the FSSP were expended. The \CMA\ shall maintain supporting documentation capable of substantiating all expenditures and reimbursements made to providers and/or families, which shall be made available to the Department upon request.
1. When the \CMA\ purchases services or items directly for families, the \CMA\ shall maintain receipts or invoices from the service provider and documentation demonstrating that the provider was paid by the \CMA\. Receipts or invoices must contain, at a minimum, member and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount due or paid.
2. When the \CMA\ reimburses families for services or items, the \CMA\ shall ensure the family provides the \CMA\ with receipts or invoices prior to reimbursement. The \CMA\ shall maintain receipts or invoices from the families, and documentation demonstrating that the family was reimbursed by the \CMA\. The \CMA\ must ensure all receipts or invoices provided by the families contain, at a minimum, member and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.
3. When the \CMA\ provides funding to the families for the purchase of services or items in advance, the \CMA\ shall notify the families that they are required to submit invoices or receipts to the \CMA\ of all purchases made prior to the close of the State Fiscal Year. The \CMA\ must ensure that all receipts or invoices are collected and maintained from the family, as well as documentation demonstrating that the family received funding from the \CMA\. The \CMA\ must ensure all receipts or invoices provided by the families contain, at a minimum, member and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

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C. The \CMA\ shall submit to the Department, on a form and frequency prescribed by the Department, information which outlines individual family use of the FSSP.
D. The \CMA\ shall report only FSSP expenditure data in the format and timeframe as designated by the Department.

FSSP Program Evaluation

E. The \CMA\, in cooperation with the local Family Support Council, shall be responsible for evaluating the effectiveness of the FSSP within its defined service area on an annual basis.
F. The evaluation may be based upon a family satisfaction survey and shall address the following areas:
    1. Effectiveness of outreach/public awareness including:
        a. The demographics of participants in comparison to demographics of the service area; and
        b. How well the program integrates with other community resources.
    2. Satisfaction and program responsiveness to include:
        a. Ease of access to the program;
        b. Timeliness of services;
        c. Effectiveness of services;
        d. Availability of services;
        e. Responsiveness to family concerns;
        f. Overall family satisfaction with services; and
        g. Recommendations.
    3. Effective coordination and utilization of funds to include:
        a. Other local services and supports utilized in conjunction with the FSSP; and
        b. Efficiency of required documentation for receipt of the FSSP.
    4. The \CMA\, and participating families as requested, shall cooperate with the Department regarding statewide evaluation and quality assurance activities, which includes, but is not limited to providing the following information:
        a. The maximum amount any one family may receive through the FSSP during the fiscal year; and
        b. The total number of families to be served during the year.

FSSP Performance and Quality Review

G. The Department shall conduct a Performance and Quality Review of the FSSP to ensure that it complies with the requirements set forth in these rules.
H. A \CMA\ found to be out of compliance with these rules through the results of the Performance and Quality Review, shall be required to develop a corrective action plan, upon written notification from the Department. A corrective action plan must be submitted to the Department within ten (10) business days of the receipt of the written request from the Department. A corrective action plan shall include, but not limited to:
    1. A detailed description of the action to be taken, including any supporting documentation;
    2. A detailed time frame specifying the actions to be taken;
    3. Employee(s) responsible for implementing the actions; and
    4. The implementation timeframes and a date for completion.
I. The \CMA\ shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The agency shall explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the agency's compliance.
    1. Upon receipt of the corrective action plan, the Department will accept, modify or reject the proposed corrective action plan. Modifications and rejections shall be accompanied by a written explanation.
    2. In the event that the corrective action plan is rejected, the agency shall re-write the corrective action plan and resubmit along with the requested documentation to the Department for review within five (5) business days.
    3. The agency shall implement the corrective action plan upon acceptance by the Department.

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4. If corrections are not made within the requested timeline and quality specified by the Department, funds may be withheld or suspended.

FSSP Annual Report

J. Each \CMA\ shall submit an annual FSSP report to the Department by October 1 of each year. The report will contain two sections.
   1. The first section must describe how the \CMA\ plans to spend the FSSP funds in the current fiscal year and will include:
      a. Description of the outreach/public awareness efforts for the coming year;
      b. Description of anticipated special projects or activities under the Program Expense service category; and
      c. Goals with measurable outcomes for any changes to the FSSP.
   2. The second section of the annual report will describe how the FSSP funds were spent in the previous year and must contain:
      a. The program evaluation outcomes for the previous year as described in this section;
      b. The total amount of funds expended by service category;
      c. The total number of families served, and the total number of families placed on the waiting list;
      d. Detailed information for the Program Expense service category to include:
         i. The total number of families that utilized services under the Program Expense category;
         ii. The specific services provided; resource library, special projects, training events, social events, or group respite;
         iii. How these services enhanced the lives of families in the community and the total number of families who participated in each project; and
         iv. The report shall include the total number of staff, total of staff cost, and other costs associated with the Program Expense service category.
      e. A description of how the annual FSSP report was distributed to eligible families; and
      f. The signature of Family Support Council (FSC) members, the FSSP Coordinator, and the \CMA\ Executive Director.

8.7559 HCBS Telehealth Delivery

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

~~I. [Definitions~~

~~A. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends, and/or caregivers), chosen by the individual, conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources.~~

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

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

~~D. Community-Centered Board (CCB) means a private corporation, for-profit or not for profit, which when designated pursuant to Section 25.5-10-209, C.R.S., provides case management services to members with developmental disabilities, is authorized to determine eligibility of such members within a specified geographical area, serves as the single point of entry for members to receive services and supports under~~

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~~Section 25.5-10-201, C.R.S. et seq , and provides authorized services and supports to such members either directly or by purchasing such services and supports from service agencies.~~

~~E. Department means the Department of Health Care Policy and Financing.~~

~~F. Home and Community Based Services (HCBS) means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a member who requires a level of institutional care that would otherwise be provided in an institutional setting.~~

~~G. Home and Community Based Services Telehealth (HCBS Telehealth) is a method of service delivery of those HCBS services listed at Section 8.615.2.~~

~~H. Medicaid State Plan means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.~~

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

~~J. Prior Authorization Request (PAR) means the Department prescribed form to authorize the reimbursement for services.~~

~~K. Support Plan means the document used for Support Planning.~~

~~L. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking services of his or her rights and responsibilities.~~

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

8.7559.01 HCBS Telehealth Inclusions

A. HCBS Telehealth may be used to deliver support through the following authorized HCBS waiver services:

1. Adult Day Services ~~[- Basic, Tier 1]~~; defined at {Section 8.7504.} ~~[Section 8.491.1;~~
2. ~~Adult Day Services - Brain Injury, Tier 1;[Sections 8.515.3 and 8.515.70]~~;
3. Behavioral Management and Education; defined at {Section 8.7507} [Section 8.516.40];
4. Behavioral {Therapies} ~~[Services]~~ Behavioral Consultation; defined in {Sections 8.7508} ~~[Sections 8.500.5.B.1. and, 8.500.94.B.2]~~;
5. Behavioral {Therapies} ~~[Services]~~ - Behavioral Counseling, Group, defined in {Section 8.7508} ~~[Sections 8.500.5.B.1, and 8.500.94.B.2]~~;
6. Behavioral {Therapies} ~~[Services]~~ - Behavioral Counseling, Individual, defined in {Section 8.7508} ~~[Sections 8.500.5.B.1, and 8.500.94.B.2]~~;
7. Behavioral {Therapies} ~~[Services]~~ - Behavioral Plan Assessment; defined in {Section 8.7508}~~[Sections 8..500.5.B.1 and , 8.500.94.B.2]~~;
8. Bereavement Counseling; defined at {Section 8.7510} ~~[Section 8.504.1]~~;
9. {Child and Youth Mentorship} ~~[Wrap Around Service - Transition Support]~~; defined at {Section 8.75XX}~~[Section 8.508.100.M]~~;
10. Community Connector; defined at {Section 8.7513} ~~[Section 8.503.40.A.3]~~;
11. ~~[Mental Health]~~Counseling {Services}, Family; defined at {Section 8.7515} ~~[Section 8.516.50]~~;
12. ~~[Mental Health]~~Counseling {Services}, Group; defined at {Section 8.7515}[Section 8.516.50];
13. ~~[Mental Health]~~Counseling {Services}, Individual; defined at {Section 8.7515} [Section 8.516.50];
14. Day Habilitation; defined at {Section 8.7516} ~~[Section 8.500.5.B.2]~~;
15. Expressive Therapy - Art and Play Therapy, Group; defined at {Section 8.7520} ~~[Sections 8.504.1 and 8.504.2.D]~~;
16. Expressive Therapy - Art and Play Therapy, Individual; defined at {Section 8.7520} ~~[Sections 8.504.1 and 8.504.2.D]~~;
17. Expressive Therapy - Music Therapy, Group; defined at {Section 8.7520}~~[Sections 8.504.1 and 8.504.2.D]~~;

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\major revision\	{combined/moved similar language}
~~[outdated reference (removed)]~~	[outdated reference (to be updated)]
Areas requiring further review	

18. Expressive Therapy - Music Therapy, Individual; defined at {Section 8.7520} ~~[Sections 8.504.1 and 8.504.2.D]~~;
19. Independent Living Skills Training; defined at {Section 8.7528} ~~[Section 8.516.10]~~;
20. Mentorship; defined at {Section 8.7531} ~~[Section 8.500.94B.10]~~;
21. Movement Therapy; defined in {Section 8.7532} ~~[Sections 8.500.94.B.15 and 8.503.40.A.8]~~;
22. Palliative/Supportive Care [~~– Care Coordination~~]; defined at {Section 8.7534} ~~[Section 8.504.1]~~;
23. Substance Use Counseling, Family; defined at {Section 8.7545} ~~[Section 8.516.60]~~;
24. Substance Use Counseling, Individual; defined at {Section 8.7545}~~[Section 8.516.60]~~;
25. Supported Employment - Job Coaching, Individual, defined in {Section 8.7546} ~~[Sections 8.500.5.B.9 and 8.500.98.C]~~;
26. Supported Employment - Job Development, Levels 1-6, Individual, defined in {Section 8.7546} ~~[Sections 8.500.5.B.9 and 8.500.98.C]~~;
27. [Transition Services -]Life Skills Training; defined at {Section 8.7529}~~[Section 8.553.1]~~;
28. [Transition Services -]Peer Mentorship; defined at {Section 8.7535}~~[Section 8.553.1]~~;
29. Therapeutic Life Limiting Illness Support, Family; defined at{Section 8.7548} ~~[Sections 8.504.1 and 8.504.2.B]~~;
30. Therapeutic Life Limiting Illness Support, Group; defined at{Section 8.7548} ~~[Sections 8.504.1 and 8.504.2.B]~~;
31. Therapeutic Life Limiting Illness Support, Individual; defined at{Section 8.7548} ~~[Sections 8.504.1 and 8.504.2.B]~~; and
32. Wraparound Services - Wraparound Plan and Prevention and Monitoring ~~[Intensive Support]~~; defined at {Section 8.7554} ~~[Section 8.508.100.H]~~. .

B. HCBS Telehealth may only be used to deliver consultation for the following services:
   1. Adaptive Therapeutic Recreational Fees and Equipment, defined at {Section 8.7503}~~[Section 8.503.40.A.1]~~;
   2. Assistive Technology; defined in {Section 8.7506} ~~[Sections 8.500.94.B.1 and, 8.503.40.A.2]~~;
   3. Home {Accessibility} Modifications and Adaptations; defined in {Section 8.7524} ~~[Sections 8.493.1, 8.500.94.B.6, and 8.503.40.A.5]~~; and
   4. Vehicle Modifications, defined in {Section 8.7551} ~~[Sections 8.500.94.B.20 and 8.503.40.A.12]~~.
   5. Providers shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules and may not bill separately for consultation.

8.7559.02 HCBS Telehealth Exclusions and Limitations

A. HCBS Telehealth is subject to the limitations of the respective service it supports as referenced in this rule at {Section 8.7559.1 (HCBS Telehealth Inclusions)} ~~[Section 8.615.2]~~.
B. HCBS Telehealth is not a duplication of Health First Colorado Telehealth or Telemedicine services.
C. HCBS Telehealth is not permitted to be used for any service not listed in this rule at {Section 8.7559.1 (HCBS Telehealth Inclusions)} ~~[Section 8.615.2]~~.

8.7559.03 HCBS Telehealth Provider Agency Requirements

A. Providers that choose to use HCBS Telehealth shall develop and make available a written HCBS Telehealth Policy which at a minimum shall include the following:
   1. The member may refuse telehealth delivery at any time without affecting the member's right to any future services and without risking the loss or withdrawal of any service to which the member would otherwise be entitled;
   2. All required and applicable confidentiality protections that apply to the services;
   3. The member shall have access to all collected information resulting from the services utilized as required by state law;
   4. How utilization of HCBS Telehealth will be made available to those members who require assistance with accessibility, translation, or have limited visual and/or auditory capabilities;
   5. A contingency plan for service delivery if technology options fail; and,

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

\major revision\	{combined/moved similar language}
~~[outdated reference (removed)]~~	[outdated reference (to be updated)]
Areas requiring further review	

6. Providers shall maintain a copy of the HCBS Telehealth Policy signed by the member in their records.

B. Providers shall ensure the use of HCBS Telehealth is the choice of the member. The HCBS waiver provider shall maintain a consent form for the use of HCBS Telehealth in the member's record.

C. Provider shall complete a provider-developed evaluation of the member and caregiver prior to using HCBS telehealth services that identifies the member's ability to participate and outlines any accommodations needed while utilizing HCBS Telehealth.

D. Providers must comply with all HIPAA and confidentiality procedures. HCBS Waiver providers must be able to use a technology solution that allows real-time interaction with the member which may include audio, visual and/or tactile technologies.

E. Providers shall not use HCBS Telehealth to address a member's emergency needs.

F. Providers shall use a HIPAA compliant technology solution meeting all privacy requirements.

[~~Case Management Requirements~~

G. ~~Members eligible to use HCBS Telehealth are those enrolled in the waivers and services as defined in this rule at Section 8.615.2.~~

H. ~~The CMA shall ensure the use of HCBS Telehealth is the choice of the member through the Support Planning process by indicating the member's choice to receive HCBS Telehealth in the Department prescribed IT system.~~

I. ~~Through the Support Planning process, the CMA shall identify and address the benefits and possible detriments to members choosing to use HCBS Telehealth for service delivery.~~

J. ~~HCBS Telehealth delivery must be prior authorized and documented in the member's Support Plan.~~

K. ~~Telehealth as a service delivery method for authorized HCBS waiver services, shall not interfere with any member rights or be used as any part of a Rights Modification plan.~~]

8.7559.04 HCBS Telehealth Reimbursement

A. HCBS Telehealth does not include reimbursement for the purchase or installation of telehealth equipment or technologies.

B. HCBS Waiver service providers utilizing Telehealth shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules. This includes the prohibition on collecting copayments or charging members for missing set times for services.