Title of Rule: Revision to the Medical Assistance Rule concerning Settings Final Rule Critical Updates, Sections 8.484, 8.500.5.B, 8.500.94.B, 8.609.4 & 8.610.
Rule Number: MSB 22-08-31-A
Division / Contact / Phone: OCL / Kyra Acuna / 5666

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   In 2014, the federal Centers for Medicare & Medicaid Services (CMS) published a rule requiring Home- and Community-Based Services (HCBS) to be provided in settings that meet certain criteria. The criteria ensure that HCBS participants have access to the benefits of community living and live and receive services in integrated, non-institutional settings. While the Department codified the federal regulations in January 2022, through 8.484, these critical rule updates remove language from other existing regulations that conflict with the federal requirements for all HCBS Waivers.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   The Settings Final Rule is being required for all states to implement by March 2023.

3. Federal authority for the Rule, if any:

   42 C.F.R. § 441.301(C)(4))

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   While the federal regulation was codified into Colorado regulations via 8.484 in January 2022, it did not address existing regulations that were in conflict with the federal regulations. These critical rule updates remove conflicts in existing regulations to ensure compliance with the federal regulation prior to the end of the federal transition period. The proposed regulation updates will impact all HCBS members, approximately 55,000 individuals. All providers who accept Medicaid funding are required to comply with these rules. Members will greatly benefit from the implementation of these rules by ensuring everyone gets the most out of community living, all services are provided in integrated settings, and the provision of services are person-centered. There should not be any further costs incurred by providers in order to come into compliance with these regulations.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The codification of the federal Final Settings Rule has a significant, positive impact on the quality of services for our members by ensuring that members have access to the benefits of community living and live and receive services in integrated, non-institutional settings. Additionally, these critical updates to regulations ensure that current regulations do not conflict with the now codified Final Settings Rule and require that services are delivered in an integrated, person-centered manner.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

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The Department has partnered with the Department of Public Health and Environment on this project. There are no additional costs to the Department or any other agency as a result of these critical rule updates.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The Department had to implement the Final Settings Rule regulations otherwise it would be out of compliance with the federal regulations. These critical rule updates ensure that other state regulations are no longer in conflict with the now implemented Final Settings Rule regulations, 8.484. By being out of compliance, there is a risk of losing the federal match on all HCBS services.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no other methods to achieve our purpose. These critical updates must be made in order to remain in compliance with federal regulations and ensure that Department regulations do not conflict with one another.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   No alternative methods were considered.

8.484 HOME- AND COMMUNITY-BASED SERVICES SETTINGS FINAL RULE

8.484.1 STATEMENT OF PURPOSE, SCOPE, AND ENFORCEMENT

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

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

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

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

   b. Professional provider offices and clinics;

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

   d. Settings where people receive individual Supported Employment services.

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

   a. At case management agencies;

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

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

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

8.484.2 DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Provider-Owned or -Controlled Non-residential Settings include, but are not limited to, provider-owned facilities where Adult Day, Day Treatment, Specialized Habilitation, Supported Community Connections, Prevocational Services, and Supported Employment Services are provided.

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

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

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

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

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

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

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

b. the use of Restraints;

c. the use of Restrictive or Controlled Egress Measures;

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

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

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

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

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

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

8.484.3 BASIC CRITERIA APPLICABLE TO ALL HCBS SETTINGS

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

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

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

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

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

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

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

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

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

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

f. Individuals have control over their personal resources. If an individual is not able to control their resources, an assessment of their skills must be completed and documented in their Person-Centered Support Plan. The assessment and Person-Centered Support Plan must identify what individualized assistance the provider or other person will provide and any training for the individual to become more independent, based on the outcome of the assessment.

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

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

a) Document the request or representative payee designation;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Each individual is afforded the opportunity to:

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

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

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

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

   e. Be free from physical abuse and inhumane treatment;

   f. Be protected from all forms of sexual exploitation;

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

   h. Exercise personal choice in areas including personal style;

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

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

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

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

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

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

8.484.4 ADDITIONAL CRITERIA FOR HCBS SETTINGS

8.484.4.A Provider-Owned or -Controlled Residential Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as

indicated in their Person-Centered Support Plan, subject to the Rights Modification process in Section 8.484.5:

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

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

        i. Provide substantially the same terms for all individuals;

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

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

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

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

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

        vii. Specify the duration of the agreement;

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

        ix. Specify expectations for maintenance;

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Individuals must have a key or key code to their home, a bedroom door with a lock and key, lockable bathroom doors, privacy in changing areas, and a lockable place for belongings, with only appropriate staff/contractors having keys to such doors and storage areas. Staff/contractors must knock and obtain permission before entering individual units, bedrooms, bathrooms, and changing areas. Staff/contractors may use keys to enter these areas and to open private storage spaces only under limited circumstances agreed upon with the individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.484.5 RIGHTS MODIFICATIONS

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

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

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

1. The right to be modified.

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

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

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

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

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

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

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

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

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

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

8.484.5.D Additional Rights Modification process requirements:

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

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

8.484.5.E Use of Restraints

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

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

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

   c. Be compliant with any applicable waiver.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.500 HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES(HCBS-DD) WAIVER

8.500.5 HCBS-DD WAIVER SERVICES

8.500.5.B DEFINITIONS OF SERVICES

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

1. Behavioral Services are services related to a Client's developmental disability which assist a Client to acquire or maintain appropriate interactions with others.

    a. Behavioral services shall address specific challenging behaviors of the Client and identify specific criteria for remediation of the behaviors.

    b. A Client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid State Plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the Client.

    c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third-party source or available from a natural support are excluded and shall not be reimbursed.

    d. Behavioral Services include:

        i) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the Client's developmental disability and are necessary for the Client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management.

        ii) Intervention modalities shall relate to an identified challenging behavioral need of the Client. Specific goals and procedures for the behavioral service shall be established.

        iii) Behavioral consultation services are limited to eighty (80) units per service plan year. One unit is equal to fifteen (15) minutes of service.

        iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

        v) Behavioral Plan Assessment Services are limited to forty (40) units and one (1) assessment per service plan year. One unit is equal to fifteen (15) minutes of service.

vi). Individual and Group Counseling Services include psychotherapeutic or psycho educational intervention that:

1) Is related to the developmental disability in order for the Client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2) Positively impacts the Client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

3) Counseling services are limited to two-hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral Line Services include direct one-to-one implementation of the Behavioral Support Plan and is:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a Client at risk of institutional placement and to address an identified challenging behavior that places the Client's health and safety or the safety of others at risk.

4) Behavioral Line Services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Requests for Behavioral Line Services shall be prior authorized in accordance with the Operating Agency's procedures.

2. Day Habilitation Services and Supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the Client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence and personal choice.

b. Day Habilitation Services and Supports encompass three (3) types of habilitative environments: specialized habilitation services, supported community connections, and prevocational services.

c. Specialized Habilitation (SH) services are provided to enable the Client to attain the maximum functioning level or to be supported in such a manner that allows the Client to gain an increased level of self-sufficiency. Specialized habilitation services:

i) ~~Are provided in a non-integrated setting where a majority of the Clients have a disability,~~Include the opportunity for Clients to select from Age Appropriate Activities and Materials, as defined in Section 8.484.2.A., both within and outside of the setting.

ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported Community Connections Services are provided to support the abilities and skills necessary to enable the Client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a Client's service plan,

ii) Are conducted in a variety of settings in which the Client interacts with persons without disabilities other than those individuals who are providing services to the Client. These types of services may include socialization, adaptive skills and personnel to accompany and support the Client in community settings,

iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

iv) May be provided in a group setting or may be provided to a single Client in a learning environment to provide instruction when identified in the service plan.

v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational Services are provided to prepare a Client for paid community employment. Services consist of teaching concepts including attendance, task completion, problem solving and safety, and are associated with performing compensated work.

i) Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for Prevocational Services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the

minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations.

iv) Prevocational Services are provided to support the Client to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment.

vi) Documentation shall be maintained in the file of each Client receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. Section 1400 et seq.).

f. The number of units available for day habilitation services in combination with prevocational services is four thousand eight hundred (4,800). When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and

g. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One unit equals fifteen (15) minutes of service.

3. Dental services are available to individuals age twenty-one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and co-pays/co-insurance,

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv). Non-intravenous sedation,

v) Basic and deep cleanings,

vi). Mouth guards,

vii) Topical fluoride treatment, and

viii) Retention or recovery of space between teeth when indicated.

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval.

e. Implants shall not be a benefit for a Client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail.

f. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at Section 8.076.1.8or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the Client.

g. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodontic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

h. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

i. Preventative and basic services are limited to $2,000 per service plan year. Major services are limited to $10,000 for the five (5) year renewal period of the waiver.

4. Home Delivered Meals as defined at Section 8.553.1.

5. Non-Medical Transportation enables Clients to gain access to Day Habilitation Services and Supports, Prevocational Services and Supported Employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

   a. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized and documented in the Service Plan.

   b. Non-Medical Transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-Medical Transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip accessed each way to and from day habilitation and supported employment services.

   c. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. Section 431.53 or transportation services under the Medicaid State Plan, defined at 42 C.F.R. Section 440.170 (a).

6. Peer Mentorship as defined at Section 8.553.1.

7. Residential Habilitation Services and Supports (RHSS) are delivered to ensure the health and safety of the Client and to assist in the acquisition, retention or improvement in skills necessary to support the Client to live and participate successfully in the community.

   a. Services may include a combination of lifelong, or extended duration supervision, training or support that is essential to daily community living, including assessment and evaluation, and includes training materials, transportation, fees and supplies.

   b. The living environment encompasses two (2) types that include individual Residential Services and Supports (IRSS) and Group Residential Services and Supports (GRSS).

   c. All RHSS environments shall provide sufficient staff to meet the needs of the Client as defined in the service plan.

   d. The following RHSS activities assist Clients to reside as independently as possible in the community:

      i) Self-advocacy training, which may include training to assist in expressing personal preferences, increasing self-representation, increasing self-protection from and reporting of abuse, neglect and exploitation, advocating for individual rights and making increasingly responsible choices,

      ii) Independent living training, which may include personal care, household services, infant and childcare when the Client has a child, and communication skills,

iii) Cognitive services, which may include training in money management and personal finances, planning and decision making,

iv) Implementation of recommended follow-up counseling, behavioral, or other therapeutic interventions. Implementation of physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

v) Medical and health care services that are integral to meeting the daily needs of the Client and include such tasks as routine administration of medications or tending to the needs of Clients who are ill or require attention to their medical needs on an ongoing basis,

vi) Emergency assistance training including developing responses in case of emergencies and prevention planning and training in the use of equipment or technologies used to access emergency response systems,

vii) Community access services that explore community services available to all people, natural supports available to the Client and develop methods to access additional services, supports, or activities needed by the Client,

viii) Travel services, which may include providing, arranging, transporting or accompanying the Client to services and supports identified in the service plan, and

ix) Supervision services which ensure the health and safety of the Client or utilize technology for the same purpose.

e. All direct care staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment and successfully complete a written test and a practical and competency test.

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

8. Specialized Medical Equipment and Supplies include:

a. Devices, controls or appliances that enable the Client to increase the Client's ability to perform activities of daily living,

b. Devices, controls or appliances that enable the Client to perceive, control or communicate within the Client's environment,

c. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items,

d. Durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address Client functional limitations, or

e. Necessary medical supplies in excess of Medicaid State Plan limitations or not available under the Medicaid State Plan.

f. All items shall meet applicable standards of manufacture, design and installation.

g. Specialized medical equipment and supplies exclude those items that are not of direct medical or remedial benefit to the Client.

9. Supported Employment includes intensive, ongoing supports that enable a Client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the Client's disabilities needs supports to perform in a regular work setting.

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

b. Supported Employment may be delivered in a variety of settings in which Clients have the opportunity to interact regularly with individuals without disabilities, other than those individuals who are providing services to the Client~~, to the same extent that individuals without disabilities employed in comparable positions would interact~~.

c. Supported Employment is work outside of a facility-based site, which is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities.

d. Supported Employment is provided in community jobs~~, enclaves~~ or mobile crews.

e. Group Employment including mobile crews ~~or enclaves~~ shall not exceed eight (8) Clients.

f. Supported Employment includes activities needed to sustain paid work by Clients including supervision and training.

g. When Supported Employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a Client as a result of the Client's disabilities.

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

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

j. Supported Employment shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.

k. The limitation for Supported Employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of Supported Employment and shall not be reimbursed:

i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a Client's supported employment.

10. Transition Setup services as defined at Section 8.553.1.

11. 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 Client who is at least twenty-one (21) years of age.

a. Lasik and other similar types of procedures are only allowable when:

i) The procedure is necessary due to the Client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective.

ii) Prior authorized in accordance with Operating Agency procedures.

8.500.94 HCBS-SLS WAIVER SERVICES

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

1. Assistive technology includes services, supports or devices that assist a Client to increase, maintain or improve functional capabilities. This may include assisting the Client in the selection, acquisition, or use of an assistive technology device and includes:

a. The evaluation of the assistive technology needs of a Client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Client in the customary environment of the Client,

b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

c. Training or technical assistance for the Client, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives of the Client,

d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-SLS waiver, and

e. Adaptations to computers, or computer software related to the Client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency procedure.

f. Assistive technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan or third party resource.

g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

h. When the expected cost is to exceed $2,500 per device three estimates shall be obtained and maintained in the case record.

i. Training and technical assistance shall be time limited, goal specific and outcome focused.

j. The following items and services are specifically excluded under HCBS-SLS waiver and not eligible for reimbursement:

i) Purchase, training or maintenance of service animals,

ii) Computers,

iii) Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of game,

iv) Training or adaptation directly related to a school or home educational goal or curriculum.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver unless an exception is applied for and approved. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health and safety of the Client or that enable the Client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures within thirty (30) days of the request.

2. Behavioral services are services related to the Client's intellectual or developmental disability which assist a Client to acquire or maintain appropriate interactions with others.

a. Behavioral services shall address specific challenging behaviors of the Client and identify specific criteria for remediation of the behaviors.

b. A Client with a co-occurring diagnosis of an intellectual or developmental disability and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the Client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral Services:

i) Behavioral consultation services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the Client's developmental disability and are necessary for the Client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management.

ii) Intervention modalities shall relate to an identified challenging behavioral need of the Client. Specific goals and procedures for the behavioral service shall be established.

iii) Behavioral consultation services are limited to eighty (80) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

v) Behavioral plan assessment services are limited to forty (40) units and one (1) assessment per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

vi) Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:

1) Is related to the developmental disability in order for the Client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2) Positively impacts the Client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

3) Counseling services are limited to two hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and are:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a Client at risk of institutional placement, and that places the Client's health and safety or the safety of others at risk

4) Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. All behavioral line services shall be prior authorized in accordance with Operating Agency procedure

3. Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the Client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.

b. Day habilitation services and supports encompass three (3) types of habilitative environments; specialized habilitation services, supported community connections, and prevocational services.

c. Specialized habilitation (SH) services are provided to enable the Client to attain the maximum functional level or to be supported in such a manner that allows the Client to gain an increased level of self-sufficiency. Specialized habilitation services:

i) ~~Are provided in a non-integrated setting where a majority of the Clients have a disability,~~Include the opportunity for Clients to select from Age Appropriate Activities and Materials, as defined in Section 8.484.2.A., both within and outside of the setting.

ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported community connections services are provided to support the abilities and skills necessary to enable the Client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a Client's service plan,

ii) Are conducted in a variety of settings in which the Client interacts with persons without disabilities other than those individuals who are providing services to the Client. These types of services may include socialization, adaptive skills and personnel to accompany and support the Client in community settings,

iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

iv) May be provided in a group setting or may be provided to a single Client in a learning environment to provide instruction when identified in the service plan.

v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational services are provided to prepare a Client for paid community employment. Services include teaching concepts including attendance, task completion, problem solving and safety and are associated with performing compensated work.

i) Prevocational services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for prevocational services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than 50 percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor regulations.

iv) Prevocational services are provided to support the Client to obtain paid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving prevocational services shall occur at least once every five years to determine whether or not the person has developed the skills necessary for paid community employment.

vi) Documentation shall be maintained in the file of each Client receiving this service that the service is not available under a program funded under Section 110 of the rehabilitation act of 1973 or the Individuals with Educational Disabilities Act (20 U.S.C. Section 1400 *et seq.*).

f. Day habilitation services are limited to seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. The number of units available for day habilitation services in combination with prevocational services and supported employment shall not exceed seven thousand one hundred and twelve (7,112) units.

4. Dental services are available to individuals age twenty-one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and co-payments

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

viii) Retention or recovery of space between teeth when indicated, and

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial,

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures

d. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at Section 8.076.1.8 r available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the Client

e. Implants shall not be a benefit for Clients who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users.

f. Subsequent implants are not a covered service when prior implants fail.

g. Full mouth implants or crowns are not covered.

h. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodontic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

i. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

j. Preventative and basic services are limited to two thousand ($2,000) per service plan year. Major services are limited to ten thousand ($10,000) for the five (5) year renewal period of the waiver.

5. Health maintenance activities are available only as a participant directed supported living service in accordance with Section 8.500.94.C. Health maintenance activities means routine and repetitive health related tasks furnished to an eligible Client in the community or in the Client's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include:

a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection. Skin care may include wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional,

b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation,

c. Mouth care performed when:

i) there is injury or disease of the face, mouth, head or neck,

ii) in the presence of communicable disease,

iii) the Client is unconscious, or

iv) oral suctioning is required,

d. Dressing, including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary,

e. Feeding

i) When suctioning is needed on a stand-by or other basis,

ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study,

iii) Syringe feeding, OR

iv) Feeding using an apparatus,

f. Exercise prescribed by a licensed medical professional including passive range of motion,

g. Transferring a Client when he/she is unable to assist or the use of a lift such as a Hoyer is needed,

h. Bowel care provided to a Client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the Client is unable to assist,

i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters,

j. Medical management required by a medical professional to monitor blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections,

k. Respiratory care, including:

i. Postural drainage,

ii) Cupping,

iii) Adjusting oxygen flow within established parameters,

iv) Suctioning of mouth and nose,

v) Nebulizers,

vi) Ventilator and tracheostomy care,

vii) Prescribed respiratory equipment.

8.500.94.B.6. HOME ACCESSIBILITY ADAPTATIONS

8.500.94.B.6.a DEFINITIONS

Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for specific Home and Community-Based Services waivers pursuant to Sections 25.5-10-209.5 and 25.5-6-106, C.R.S. and pursuant to a provider participation agreement with the state Department.

Case Manager means a person who provides case management services and meets all regulatory requirements for case managers.

The Division of Housing (DOH) is a division within the Colorado Department of Local Affairs that is responsible for approving Home Accessibility Adaptation PARs, oversight on the quality of Home Accessibility Adaptation projects, and inspecting Home Accessibility Adaptation projects, as described in these regulations.

1. DOH oversight is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, all oversight functions shall be performed by the Department unless specifically allowed by the Participant or their guardian to be performed by DOH.

Home Accessibility Adaptations means the most cost-effective physical modifications, adaptations, or improvements in a Participant's existing home setting which, based on the Participant's medical condition or disability: Participant

1. Are necessary to ensure the health and safety of the Participant;

2. Enable the Participant to function with greater independence in the home; or

3. Prevent institutionalization or support the deinstitutionalization of the Participant.

Home Accessibility Adaptation Provider means a provider agency that meets the standards for Home Accessibility Adaptation described in Section 8.500.94.B.6.e and is an enrolled Medicaid provider.

Person-Centered Planning means Home Accessibility Adaptations that are agreed upon through a process that is driven by the Participant and can include people chosen by the Participant, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations; and where the Participant is provided necessary information, support, and choice Participant to ensure that the Participant directs the process to the maximum extent possible.

8.500.94.B.6.b INCLUSIONS

8.500.94.B.6.b.i Home Accessibility Adaptations may include, but are not limited to the following:

a) Installing or building ramps;

b) Installing grab-bars or other Durable Medical Equipment (DME) if such installation cannot be performed by a DME supplier;

c) Widening or modification of doorways;

d) Modifying a bathroom facility for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

e) Modifying a kitchen for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

f) Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies;,

g) Installing stair lifts or vertical platform lifts;

h) Modifying an existing second exit or egress window to lead to an area of rescue for emergency purposes;

i) The modification of a second exit or egress window must be approved by the Department or DOH at any funding level as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the Participant.

i) Safety enhancing supports such as basic fences, strengthened windows, and door and window alerts.

8.500.94.B.6.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of Section 8.500.94.B.6.

8.500.94.B.6.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.

8.500.94.B.6.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.

8.500.94.B.6.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.

a) Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the Participant, or enable the Participant to function with greater independence in the home, if:

i) The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and

ii) Either:

1. There is an immediate risk to the Participant's health or safety, or

2. There has been a significant change in the Participant's needs since a previous Home Accessibility Adaptation.

b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule at Section 8.500.94.B.6.

8.500.94.B.6.c. EXCEPTIONS AND RESTRICTIONS

8.500.94.B.6.c.i. Home Accessibility Adaptations must be a direct benefit to the Participant and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.

8.500.94.B.6.c.ii. Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, are prohibited.

8.500.94.B.6.c.iii. Adaptations, improvements, or modifications as a part of new construction costs are prohibited.

a) Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.

b) Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i) improve entrance or egress to a residence; or,

ii) configure a bathroom to accommodate a wheelchair.

c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department requirements found in this rule at Section 8.500.94.B.6.

8.500.94.B.6.c.iv. The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.

8.500.94.B.6.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.

8.500.94.B.6.c.vi. Upgrades beyond what is the most cost-effective means of meeting the Participant's identified need, including, but not limited to items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

8.500.94.B.6.c.vii. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

a) Roof repair,

b) Central air conditioning,

c) Air duct cleaning,

d) Whole house humidifiers,

e) Whole house air purifiers,

f) Installation or repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,

g) Monthly or ongoing home security monitoring fees,

h) Home furnishings of any type,

i) HOA fees.

8.500.94.B.6.c.viii. Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.

8.500.94.B.6.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.500.94.B.6.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.500.94.B.6.d CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.500.94.B.6.d.i. The Case Manager shall consider alternative funding sources to complete the Home Accessibility Adaptation. The alternatives considered and the reason they are not available shall be documented in the case record.

1) The Case Manager must confirm that the Participant is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding. Case Managers may request confirmation of a property owner's obligations through DOH.

8.500.94.B.6.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval and confirmation of Home Accessibility Adaptation fund availability.

8.500.94.B.6.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization Request form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6. Home Accessibility Adaptations submitted with improper documentation will not be approved.

2) The Case Manager and CMA are responsible for retaining and tracking all documentation related to a Participant's Home Accessibility Adaptation funding use and communicating that information to the Participant and Home Accessibility Adaptation providers. The Case Manager may request confirmation of a Participant's Home Accessibility Adaptation fund use from the Department or DOH.

3) The Case Manager shall discuss any potential plans to move to a different residence with the Participant or their guardian and advise them on the most prudent utilization of available funds.

8.500.94.B.6.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1) An occupational or physical therapist (OT/PT) shall assess the Participant's needs and the therapeutic value of the requested Home Accessibility Adaptation. When an OT/PT with experience in Home Accessibility Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Accessibility Adaptation would contribute to a Participant's ability to remain in or return to his/her home, and how the Home Accessibility Adaptation would increase the Participant's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

a) The evaluation must be performed in the home to be modified. If the Participant is unable to access the home to be modified without the modification, the OT/PT must evaluate the Participant and home separately and document why the Participant was not able to be evaluated in the home.

2) The evaluation may be provided by a home health agency or other qualified and approved OT/PT through the Medicaid Home Health benefit.

a) A Case Manager may initiate the OT/PT evaluation process before the Participant has been approved for waiver services, as long as the Participant is Medicaid eligible.

b) A Case Manager may initiate the OT/PT evaluation process before the Participant physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

c) OT/PT evaluations performed by non-enrolled Medicaid providers may be accepted when an enrolled Medicaid provider is not available. A Case Manager must document the reason why an enrolled Medicaid provider is not available.

3) The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Participant's needs. The Case Manager shall document these alternatives and why they did not meet the Participant's needs in the Participant's case file.

8.500.94.B.6.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:

1) The Case Manager shall assist the Participant in soliciting bids from at least two Home Accessibility Adaptation Providers for Home Accessibility Adaptations estimated to cost $2,500 or more. Participant choice of provider shall be documented throughout.

2) The Case Manager must verify that the provider is an enrolled Home Accessibility Adaptation Provider for Home Accessibility Adaptations.

4) The bids for Home Accessibility Adaptations at all funding levels shall include a breakdown of the costs of the project and the following:

a) Description of the work to be completed,

b) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by

the square foot. Labor costs should include price per hour,

c) Estimate for building permits, if needed,

d) Estimated timeline for completing the project,

e) Name, address and telephone number of the Home Accessibility Adaptation Provider,

f) Signature, physical or digital, of the Home Accessibility Adaptation Provider,

g) Signature, physical or digital, or other indication of approval, such as email approval, of the Participant or their guardian, that indicates all aspects of the bid have been reviewed with them,

h) Signature, physical or digital of the home owner or property manager if the home is not owned by the Participant or their guardian.

5) Home Accessibility Adaptation Providers have a maximum of thirty (30) days to submit a bid for the Home Accessibility Adaptation project after the Case Manager has solicited the bid.

a) If the Case Manager has made three attempts to obtain a bid from a second Home Accessibility Adaptation Provider and the provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

6) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.500.94.B.6. and the recommendations of the OT/PT evaluation.

a) If a Participant or homeowner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

7) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.500.94.B.6.

8.500.94.B.6.d.vi. If a property to be modified is not owned by the Participant, the Case Manager shall obtain physical or digital signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein.

1) Written consent of the homeowner or property manager is required for all projects that involve permanent installation within the Participant's residence or installation or modification of any equipment in a common or exterior area.

2) The authorization shall include confirmation that the home owner or property manager agrees that if the Participant vacates the property, the Participant may choose to either leave the modification in place or remove the modification, that the home owner or property manager may not hold any party responsible for removing all or part of a Home Accessibility Adaptation project, and that if the Participant chooses to remove the modification, the property must be left in equivalent or better than its pre-modified condition.

8.500.94.B.6.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation, the Department may hold the CMA financially liable for the increased cost.

8. 500.94.B.6.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR. Visit may be completed using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk (e.g. natural disaster, pandemic, etc.).

8.500.94.B.6.e PROVIDER RESPONSIBILITIES

8.500.94.B.6.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in Section 8.500.98.

8.500.94.B.6.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the Home Accessibility Adaptation services will be performed, if required by that city or county.

8.500.94.B.6.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

1) If any changes to the approved scope of work are made without DOH or Department authorization, the cost of those changes will not be reimbursed.

2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi

8.500.94.B.6.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's expense.

1) The provider shall give the Participant or their guardian all manufacturer's or seller's warranties on completion of work.

8.500.94.B.6.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications (2018) developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8.500.94.B.6.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Accessibility Adaptation projects may be inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. Participants must provide access for inspections.

1) DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion for sampled projects, or receipt of a Participant's reasonable request.

2) DOH shall produce a written inspection report within the time frame agreed upon in the Home Accessibility Adaptations work plan that notes the Participant's specific complaints. The inspection report shall be sent to the Participant, Case Manager, and provider.

3) Home Accessibility Adaptation Providers must repair or correct any noted deficiencies within twenty (20) days or the time required in the inspection report, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

8.500.94.B.6.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis for non-payment or recovery of payment by the Department.

1) Volunteer work on a Home Accessibility Adaptation project approved by the Department shall be completed under the supervision of the Home Accessibility Adaptation Provider as stated on the bid.

a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family of the Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

8.500.94.B.6.f REIMBURSEMENT

8.500.94.B.6.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments.

8.500.94.B.6.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8.500.94.B.6.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation to DOH:

1) Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2) Required permits;

3) One-year written warranty on materials and labor; and

4) Documentation in the Participant's file that the Home Accessibility Adaptation has been completed satisfactorily through:

a) Receipt of the inspection report approving work from the state, county, or local building, plumbing, or electrical inspector;

b) Approval by the Participant, representative, or other designee;

c) Approval by the homeowner or property manager;;

d) A final on-site inspection report by DOH or its designated inspector; or

e) DOH acceptance of photographs taken both before and after the Home Accessibility Adaptation.

8.500.94.B.6.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8.500.94.B.6.f.v. The Home Accessibility Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.

1) All required repairs noted on inspections shall be completed before the Home Accessibility Adaptation Provider submits a final claim for reimbursement.

2) If a Home Accessibility Adaptation Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the provider during an inspection. The provider shall only be reimbursed for the value of the work completed satisfactorily.

a) A Home Accessibility Adaptation Provider may request DOH perform one (1) reconsideration of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the provider's expense.

8.500.94.B.6.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.

1) Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 7 day deadline and be supported by documentation, including Participant notification.

2) The Home Accessibility Adaptation reimbursement reduced pursuant to this subsection shall be considered part of the Participant's remaining funds.

8.500.94.B.6.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

7. Home Delivered Meals as defined at Section 8.553.1.

8. Homemaker services are provided in the Client's home and are allowed when the Client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of homemaker services:

   a. Basic homemaker services include cleaning, completing laundry, completing basic household care or maintenance within the Client's primary residence only in the areas where the Client frequents.

      i) Assistance may take the form of hands-on assistance including actually performing a task for the Client or cueing to prompt the Client to perform a task.

      ii) Lawn care, snow removal, air duct cleaning, and animal care are specifically excluded under the HCBS-SLS waiver and shall not be reimbursed.

   b. Enhanced homemaker services include basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning

      i) Habilitation services shall include direct training and instruction to the Client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the Client or enhanced prompting and cueing.

      ii) The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task:

         1) When such support is incidental to the habilitative services being provided, and

         2) To increase the independence of the Client,

      iii) Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the Client.

      iv) Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the Client's disability.

9. Life Skills Training (LST) as defined at Section 8.553.1.

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

a. Assistance in interviewing potential providers,

b. Assistance in understanding complicated health and safety issues,

c. Assistance with participation on private and public boards, advisory groups and commissions, and

d. Training in child and infant care for Clients who are parenting children.

e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.

f. Mentorship services are limited to one hundred and ninety-two (192) units (forty-eight (48) hours) per service-plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. Units to provide training to Clients for child and infant care shall be prior authorized beyond the one hundred and ninety-two (192) units per service plan year in accordance with Operating Agency procedures.

11. Non-medical transportation services enable Clients to gain access to day habilitation, prevocational and supported employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band

a. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the service plan.

b. Non-medical transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-medical transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip charge assessed each way to and from day habilitation and supported employment services.

c. Transportation provided to destinations other than to day program or supported employment is limited to four (4) trips per week reimbursed at mileage band one

d. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. 440.170. Non-emergency medical transportation is a benefit under the Medicaid State Plan, defined at 42 C.F.R. Section 440.170(a)(4).

12. Peer Mentorship as defined at Section 8.553.

13. Personal Care is assistance to enable a Client to accomplish tasks that the Client would complete without assistance if the Client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the Client or cueing to prompt the Client to perform a task. Personal care services include:

a. Personal care services include:

i) Assistance with basic self-care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.

ii) Assistance with money management,

iii) Assistance with menu planning and grocery shopping, and

iv) Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments, support that may include accompanying Clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.

b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.

c. If the annual functional needs assessment identifies a possible need for skilled care: then the Client shall obtain a home health assessment.

i. The Client shall obtain a home health assessment, or

ii. The Client shall be informed of the option to direct his/her health maintenance activities pursuant to Section 8.510, et seq.

14. Personal Emergency Response System (PERS) is an electronic device that enables Clients to secure help in an emergency. The Client may also wear a portable “help” button to allow for mobility. PERS services are covered when the PERS system is connected to the Client’s phone and programmed to a signal a response center when a “help” button is activated, and the response center is staffed by trained professionals.

a. The Client and the Client’s case manager shall develop a protocol for identifying who should to be contacted if the system is activated.

15. Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or behavioral need. Professional services include:

a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.

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

c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes watsu.

d. Professional services may be reimbursed only when:

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

ii) The intervention is related to an identified medical or behavioral need, and

iii) The Medicaid State plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

e. A pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes.

f. The following services are excluded under the HCBS Waiver from reimbursement;

i) Acupuncture,

ii) Chiropractic care,

iii) Fitness trainer

iv) Equine therapy,

v) Art therapy,

vi) Warm water therapy,

vii) Experimental treatments or therapies, and.

viii) Yoga.

16. Respite service is provided to Clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the Client.

a. Respite may be provided:

i) In the Client's home and private place of residence,

ii) The private residence of a respite care provider, or

iii) In the community.

b. Respite shall be provided according to individual or group rates as defined below:

i) Individual: the Client receives respite in a one-on-one situation. There are no other Clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty-four (24)-hour period.

ii) Individual Day: the Client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period.

iii) Overnight Group: the Client receives respite in a setting which is defined as a facility that offers 24-hour supervision through supervised overnight

group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.

iv) Group: the Client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.

c. The following limitations to respite services shall apply:

i) Federal financial participation shall not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved pursuant to. by the state that is not a private residence.

ii) Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.

iii) Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight group respite rate shall not exceed the respite daily rate.

17. Remote Supports means services as defined at Section 8.488

18. Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the Client's disability and that enable the Client to increase the Client's ability to perform activities of daily living or to safely remain in the home and community. Specialized medical equipment and supplies include:

a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. Specially designed clothing for a Client if the cost is over and above the costs generally incurred for a Client's clothing;

c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-SLS waiver.

d. The following items are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement::

i) Items that are not of direct medical or remedial benefit to the Client are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement. These include but are not limited to; vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

19. Supported Employment services includes intensive, ongoing supports that enable a Client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the Client's disabilities needs supports to perform in a regular work setting.

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

b. Supported employment may be delivered in a variety of settings in which Clients have the opportunity to interact regularly with individuals without disabilities, other than those individuals who are providing services to the Client~~, to the same extent that individuals without disabilities employed in comparable positions would interact~~.

c. Supported employment is work outside of a facility-based site, that is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities,

d. Supported employment is provided in community jobs~~, enclaves~~ or mobile crews.

e. Group employment including mobile crews ~~or enclaves~~ shall not exceed eight Clients.

f. Supported employment includes activities needed to sustain paid work by Clients including supervision and training.

g. When supported employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a Client as a result of the Client's disabilities.

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

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

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

k. The limitation for supported employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of supported employment and shall not be reimbursed:

   i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

   ii) Payments that are distributed to users of supported employment, and

   iii) Payments for training that are not directly related to a Client's supported employment.

20. Transition Setup as defined at Section 8.553.1.

21. Vehicle modifications are adaptations or alterations to an automobile or van that is the Client's primary means of transportation; to accommodate the special needs of the Client; are necessary to enable the Client to integrate more fully into the community; and to ensure the health and safety of the Client.

    a. Upkeep and maintenance of the modifications are allowable services.

    b. Items and services specifically excluded from reimbursement under the HCBS Waiver include:

        i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the Client,

        ii) Purchase or lease of a vehicle, and

        iii) Typical and regularly scheduled upkeep and maintenance of a vehicle.

    c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall ensure the health and safety of the Client, enable the Client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.

22. 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 Client who is at least 21 years of age

    a. Lasik and other similar types of procedures are only allowable when:

    b. The procedure is necessary due to the Client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and

    c. Prior authorized in accordance with Operating Agency procedures.

8.609 PROGRAM SERVICES AND SUPPORTS

8.609.4 COMPREHENSIVE HABILITATION SERVICES AND SUPPORTS

Medicaid funded Comprehensive Habilitation Services and Supports are provided through the Home and Community Based Services program which is described in the Colorado Department of Health Care Policy and Financing rules and regulations, Medical Assistance staff manual, section 8.500 (10 C.C.R. 2505-10) and the Department's program descriptions. State funded Comprehensive Habilitation Services and Supports are provided pursuant to the Department's program description. Comprehensive Habilitation Services and Supports specifically for individuals with developmental disabilities include:

A. Residential Habilitation Services and Supports

1. Individual Residential Services and Supports

2. Group Residential Services and Supports

B. Day Habilitation Services and Supports

1. Integrated employment services

2. Integrated activities services

3. ~~Non-integrated work~~Prevocational services

4. ~~Non-integrated~~Other activities services

C. Transportation Acquisition Services

8.609.9 DAY HABILITATION SERVICES AND SUPPORTS

A. Day Habilitation Services and Supports provide training, support and supervision activities which maximize functional abilities and skills necessary to enable adults to access the community and/or provide the basis for building skills which will assist individuals to access the community.

1. Day Habilitation Services and Supports are to be provided outside of the person's living environment, unless otherwise indicated by the person's needs, through meaningful employment, activities and community participation. If services cannot be provided outside of the living environment due to a person's medical or safety needs, this shall be documented.

2. Integrated employment should be considered as the primary option for all persons receiving Day Habilitation Services and Supports.

3. Day Habilitation Services and Supports include:

a. Integrated employment services (supported employment) which provide individuals with considerable ongoing job related services and supports to obtain and maintain paid work in a regular community work setting.

b. Integrated activities services which utilize the community as a learning environment to provide individuals access to, and participation in, typical activities and functions of community life. These services provide a variety of opportunities to facilitate relationships and natural supports in the community

through activities such as volunteer work, community education or training and retirement activities.

c. ~~Non-integrated work~~Prevocational services which are ~~focused on providing supervision to persons who are engaged in remunerative work and instructions, as needed, to perform remunerative work~~provided in accordance with Section 8.500.5.B.2.e. ~~These services are provided in sheltered/segregated settings in which the majority of individuals have a disability or the primary purpose of the agency/business is to provide training or day activities for individuals with disabilities.~~

d. ~~Non-integrated activities~~Other services engage individuals in a variety of functional activities which are primarily habilitative in nature with an emphasis on skill development and focus on generalizing those skills. ~~These activities are provided in sheltered/segregated settings in which the majority of individuals have a disability or the primary purpose of the agency/business is to provide training or day activities for individuals with disabilities~~.

B. The physical facilities where day habilitation services are provided shall meet requirements for physical facilities pursuant to section 8.610.

C. Each program approved service agency shall have written plans to address emergencies regardless of service location or type of program.

8.610 FACILITY BASED ADULT DAY HABILITATION SERVICES AND SUPPORTS

The physical facilities where Adult Day Habilitation Services and Supports are provided to individuals receiving comprehensive or supported living services shall meet all applicable fire, building, licensing and health regulations.

A. The physical facilities over which the service agency exercises control shall also meet the following requirements:

1. The physical facilities shall be inspected by the local fire authority prior to occupancy and at least once every three years thereafter. The local fire authority shall be informed of the purpose of the facility and potential mobility or ambulation needs of individuals served. If the purpose of the facility changes and impacts the individuals to be served in that facility, then the service agency shall be responsible for informing the local fire authority to determine if another inspection is required.

2. The service agency shall conduct fire drills at least quarterly at each physical facility.

3. All physical facilities shall have smoke detectors and fire extinguishers.

4. All physical facilities shall have first-aid supplies available.

5. All program approved service agencies shall comply with the Americans with Disabilities Act (ADA) with regard to physical facilities.

B. If the service agency provides services in the community to persons who may visit the offices of the service agency (or another service operated facility), but the persons receive services at such location(s) for less than one hour per visit, requirements of section 8.610.A.1-4 do not apply. The service agency shall, however, ensure that the facility complies with the ADA and contains no hazards which could jeopardize the health or safety of persons visiting the site.

C. For physical facilities used as community integrated sites over which the service agency exercises little or no control, the program approved service agency shall:

1. Conduct an on-site visit to ensure that there is no recognizable safety or health hazards which could jeopardize the health or safety of individuals;

2. Address any safety or health hazards which could jeopardize the health or safety of individuals with the owner/operator of the physical facility.

D. Each program approved service agency shall have written plans to address emergencies which occur during service hours regardless of service location or type of program.