Title of Rule: Revision to the Medical Assistance Act Rule concerning Community First Choice Section 8.7000.
Rule Number: MSB 24-07-11-A
Division / Contact / Phone: Office of Community Living / Eileen Saunders / 303-866-2354

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).

   Community First Choice (CFC), also known as 1915(k), is an optional Medicaid program that allows states to offer select home and community-based services and supports to eligible members on the State Plan, expanding these long-term care services to more Health First Colorado (Colorado's Medicaid Program) members. Not only does CFC expand select 1915(c) waiver services to all members eligible for CFC, but it gives members the ability to self-direct their care to the extent of their choosing. CFC gives members access to service delivery models that allow them to control their own budget, select and dismiss their attendants, and provide training for the people who provide their care. By expanding these options, members will experience greater choice and control over how they receive services. Furthermore, the CFC option provides a 6-percentage point increase in Federal matching payments to states for CFC service expenditures.

   This rule expands and streamlines existing legal authority, member rights, case management agency responsibilities, and provider agency requirements that exist within other Long-Term Services and Supports programs (LTSS), such as HCBS waivers, to include CFC. This rule amends existing HCBS services, changing eligibility from HCBS waivers to CFC, and makes necessary changes to services and provider requirements due to CFC. Finally, this rule creates a new section that outlines general provisions and eligibility for the CFC program.

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: N/A

3. Federal authority for the Rule, if any:

   1915 (k), State Plan Amendment (CO-24-0035) approved in December 2024 with an effective date of July 1, 2025. Proposed rule anticipated to be effective 7/1/2025.

4. State Authority for the Rule:

Initial Review	**04/11/25**	Final Adoption	**05/09/25**
Proposed Effective Date	**06/30/25**	Emergency Adoption	

DOCUMENT #01

Title of Rule: Revision to the Medical Assistance Act Rule concerning Community First Choice Section 8.7000.
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Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);
Sections 25.5-6-1901 through 25.5-6-1905, C.R.S (2024);

Initial Review	**04/11/25**	Final Adoption	**05/09/25**
Proposed Effective Date	**06/30/25**	Emergency Adoption	

DOCUMENT #01

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REGULATORY ANALYSIS

5. 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.

   The Department anticipates that the proposed rule will have a positive impact on Health First Colorado members who access Long-Term Services and Supports (LTSS), such as HCBS Waivers, and all Medicaid-eligible individuals who meet an institutional level of care. This rule allows the Department to implement CFC. The implementation of CFC will expand existing waiver services, such as personal care, to populations not currently covered by the HCBS waivers but still need this vital care. CFC will also make select HCBS services, such as In-Home Support Services (IHSS), available to all existing waiver members, regardless of diagnosis or disability. Through CFC, all eligible members will have the option to self-direct their care to the extent of their choosing. Through the implementation of CFC, more Coloradans will have access to a wider array of services and delivery options to meet their long-term care needs.

   The Department anticipates that Case Management Agencies and HCBS Service providers will see an increased workload due to an increase in member enrollment from the State Plan.

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

   Health First Colorado members who access LTSS will experience an increase in choice and independence with the passage of this rule. Stakeholders have advocated for the implementation of the CFC program since it became a federally available option through the Affordable Care Act. By implementing CFC through this proposed rule, the Department will streamline existing HCBS waiver services by eliminating differences within these services depending on a member's age, diagnosis, or disability. This rule is most impactful to children. This rule will ensure that children have greater access to services that support them with activities of daily living (ADL) and instrumental activities of daily living (IADL) and will allow for more flexibility when accessing these services by expanding caregiver options to allow for families to provide more care.

The Department anticipates that Case Management Agencies may see an increased workload due to members who have historically been ineligible for LTSS now being eligible for services under CFC.

The Department has worked internally and externally to mitigate any negative impacts on Case Managers and providers. Additionally, the Department has delayed the implementation of other interconnected projects to mitigate burden to the current Case Management and Long Term Services and Supports systems. The Department has conducted extensive stakeholder engagement on these issues and has pivoted to amend policies where possible.

Finally, there will likely be both positive and negative impacts to existing provider agencies. There are historical inequities between provider rates for providers who are providing the same service depending on the waiver the member is on. With the implementation of CFC, these differences can no longer exist. Thus, some providers will experience an increase in rates while others will experience a decrease.

7. 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.

   The Department anticipates a cost savings with the implementation of this rule. Under CFC, certain services that assist with ADLs and IADLs will be moving from the 1915(c) waivers and under the 1915(k) CFC. The federal government provides a 50/50 match on funding for HCBS waiver services. The state is able to claim a 6-percentage point increase in Federal matching payments for service expenditures under CFC. Given this enhanced match, the Department anticipates over $40 million in savings. All costs and potential savings associated with this rule have been approved by the Joint Budget Committee.

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

   Inaction on this rule would cause a delay in implementation of CFC. A delay to CFC implementation would mean the state does not have a set of rules and regulations to accompany the effective State Plan Amendment with CMS, risk noncompliance with state statute, jeopardize the state and Department budget, and cause a negative effect on stakeholders. Senate Bill 23-289 mandates that the Department seek federal approval through a State Plan Amendment from the CMS by July 1, 2025. The State

Plan Amendment was approved in December 2024 with an effective date of July 1, 2025. CMS expects that any approved federal program is live at the time of the effective date.

Part of the budgetary approval for CFC included the creation of a cash fund to move the General Fund savings that accrue from the enhanced federal match from the first twelve months of implementation to maintain state expenditures. The Department would then move the revenue that has accumulated in the cash fund back to the General Fund after the 12-month maintenance of state expenditure period has concluded. Thus, a delay in implementation would mean that the state would not see those savings in the fiscal year the savings were accounted for. This would require a rebalancing of the Department's budget and require the Department to account for the $40 million from other programs.

Finally, the Department has maintained significant stakeholder support for the implementation of this program. A delay in implementation would mean that members cannot access critical services and service delivery models they need and have been anticipating in 2025/2026.

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

   This proposed rule is the most cost effective and least intrusive method to ensure more members can access these critical services and service delivery models.

10. 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.

    Per CRS 25.5-6-1901-1903, the Department sought federal approval for the CFC program through a State Plan Amendment. The State Plan Amendment will be effective on July 1, 2025. Thus, the Department must put forth regulations for the program to ensure compliance with our State Plan.

    There are few alternative options as impactful as CFC to provide expanded access to home and community-based services while receiving a higher federal match. The Department has analyzed the implications and costs associated with implementing CFC for almost 15 years. The analyses for this program have included two contracted studies, internal analysis, and stakeholder review. The Department has concluded that CFC is the best path forward to provide the services and supports needed for Coloradoans while saving the state money.

8.7000 Home and Community-Based Services

8.7000.A Legal Authority

1. Authority

   a. These rules are promulgated under the authorities established in Section 25.5-10, C.R.S.

   b. These rules and the program guidelines, standards and policies of the Colorado Department of Health Care Policy and Financing, shall apply to all Case Management Agencies, Community Centered Boards, Provider Agencies and regional centers receiving funds administered by the Colorado Department of Health Care Policy and Financing.

2. Scope and Purpose

   a. These rules govern services and supports for individuals with disabilities authorized and funded in whole or in part through the Colorado Department of Health Care Policy and Financing. These services and supports include the following, as provided by the Colorado Revised Statutes and through annual appropriation authorizations by the Colorado General Assembly:

      i. Services and supports provided to residents of a State operated facility or program or purchased by the Department.

      ii. The purchase of services and supports through Community Centered Boards, Case Management Agencies, and Provider Agencies.

      iii. Other services and supports specifically authorized by the Colorado General Assembly.

      iv. Services and supports funded through ~~the~~ Home and Community-Based Services ~~waivers~~ under Sections 1915(c), 1915(k), 1902(a)(10), and 1902(a)(1) of the Social Security Act and under Section 25.5- 4-401, et seq., C.R.S.

3. Consequences for Non-Compliance

   a. Pursuant to Title 25.5, Article 10, C.R.S., upon a determination by the Executive Director or designee that services and supports have not been provided in accordance with the program or financial administration standards contained in these rules, the Executive Director or designee may reduce, suspend, or withhold payment to a Case Management Agency, or Provider Agency from which the Department purchases services or supports directly.

   b. Prior to initiating action to reduce, suspend, or withhold payment to a Case Management Agency, for failure to comply with rules and regulations of the Department, the Executive Director or designee shall specify the reasons therefore in writing and shall specify the actions necessary to achieve compliance.

4. The Department retains the authority to enter emergency orders, when necessary, to preserve the health, safety or welfare of the public or of persons receiving services, including, but not limited to, situations that:

a. Are ongoing or likely to recur if not promptly corrected or otherwise resolved and, likely to result in serious harm to the individual or others; or,

b. Arise out of a Provider Agency discontinuance of operation generally, or discontinuance of services to a particular individual because the Provider Agency is unable to ensure that person's safety or the safety of others.

5. The party requesting the Department to enter an emergency order shall submit all relevant documentation to the Department to which the opposing party shall have the opportunity to respond. The Department may request additional information as needed and shall determine the timeframes for the submission of documentation and responses. In addition to ruling on the request for emergency order, the Department may review the substantive issues involved in the dispute and determine the required course of action.

8.7001 Home and Community-Based Services Member Rights and Responsibilities

8.7001.A Definitions: Unless otherwise specified, the following definitions apply throughout Sections 8.7000-8.76500.

1. 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.

1-A. Community First Choice (CFC) means services and supports authorized by a 1915(k) granted pursuant to the Social Security Act and provided in home or community settings to a Member who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, inpatient psychiatric institution for individuals under 21 years of age, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

1-B. Contractor means an individual who performs work on behalf of a Provider Agency but is not an employee of the Agency.

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

3. Discrimination means the unfair or prejudicial treatment of people and groups based on characteristics such as race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

3-B. Guardian means an individual at least 21 years of age, resident, or non-resident, who has qualified as a Guardian of a minor or incapacitated person pursuant to appointment by a Parent or by the court. The term includes a limited, emergency, and temporary substitute Guardian as set forth in Section 15-14-102 (4), C.R.S, but not a Guardian Ad Litem.

4. Home and Community-Based Services (HCBS) Setting means any physical location where Covered HCBS are provided.

a. 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.

b. 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 Section 8.7001.B apply to the setting as a whole and protect the rights of all individuals receiving services at the setting regardless of payer source.

5. 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 8.7001.B.4 and has signed the Department-prescribed form to that effect.

6. 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 limits an individual's privacy, autonomy, access to the community, or other rights protected in Section 8.7001.B, because of the individual's challenging behavior(s).

7. Legally Authorized Representative means a person with legal authority to represent an individual in a particular matter. Such a person may be:

a. the Parent of a minor;

b. the court-appointed Guardian of an individual, only with respect to matters within the scope of, and in the manner authorized by, the guardianship order; or

c. anyone granted authority pursuant to any other type of court order or voluntary appointment or designation (e.g., conservator, agent under power of attorney, member of a supportive community in connection with a supported decision-making agreement, Long-Term Services and Supports Representative under Section 8.7001.A.8, or Authorized Representative under Sections 8.7515 or 8.7528), only with respect to matters within the scope of, and in the manner authorized by, the court order or voluntary appointment or designation.

In situations arising under subsections b and c, the applicable court order or voluntary appointment or designation must be consulted to determine whether it is still in effect, and to ensure the appointed or designated person exercises only those powers it specifically grants.

8. Long-Term Services and Supports Representative means a person designated by the individual receiving services, by the Parent of a minor, or by the Guardian of the Member receiving services, if appropriate, to assist the individual in acquiring or utilizing part or all of their Long-Term Services and Supports. This term encompasses any authorized representative as defined by Sections 25.5-6-1702 and 25.5-10-202, C.R.S.

a. A Long-Term Services and Supports Representative shall have the judgment and ability to assist the individual in acquiring and utilizing the services covered by the designation.

b. The appointment of a Long-Term Services and Supports Representative shall be in writing and shall be subject to the standards set forth in Section 8.7001.C.5.

8-B. Member means a person enrolled in the state medical assistance program, the children's basic health plan, HCBS waiver program, Community First Choice, or State General Fund program.

9. 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 Agency or by an independent Contractor providing nonresidential services.

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

10. Other Residential Setting means a physical location that is residential and that is not owned, leased, operated, or managed by an HCBS Provider Agency or by an independent Contractor providing residential services.

a. 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 Provider Agencies.

11. 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, identifies the supports needed for the individual to achieve personally identified goals, and is based on respecting and valuing individual preferences, strengths, and contributions.

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

12-B. Provider Agency means an Agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at Section 8.7500.

13. 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 Agency or by an independent Contractor providing non-residential services.

a. 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, Supported Employment Services, and Youth Day Services (including Youth Day Services at homes owned, leased, or operated by Provider Agencies/independent Contractors) are provided.

14. 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 Agency or by an independent Contractor providing residential services.

a. 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) (Group Residential Services and Supports (GRSS)); Host Homes for

adults with IDD; any Individual Residential Services and Supports (IRSS) setting that is owned or leased by a service Provider Agency or independent Contractor of a Provider Agency; 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; and Mental Health Transitional Living Homes.

14-B. Provider Participation Agreement means the contract between the Department and the Provider Agency that describes the terms and conditions governing participation in the programs administered by the Department.

15. 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 limits an individual's autonomy or other rights protected in Section 8.7001.B.

16. 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.

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

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

i. the use of Intensive Supervision if deemed a Rights Modification under the definition in Section 8.7001.A.6 above;

ii. the use of Restraints;

iii. the use of Restrictive or Controlled Egress Measures;

iv. modifications to the other rights in Section 8.7001.B.2 (basic criteria applicable to all HCBS Settings) and Section 8.7001.B.3 (additional criteria for HCBS Settings);

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

vi. rights ~~suspension~~modifications under Section 25.5-10-218(3), C.R.S.

vi. ~~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.~~

b. Modifications to the rights to dignity and respect, the rights in Sections 8.7001.B.2.a.vi-vii covering such matters as Person-Centeredness, civil rights, and freedom from abuse, and the right to physical accessibility are not permitted.

c. For children under age 18, a limitation or restriction to any of the rights in Sections 8.7001.B.2 and 8.7001.B.3 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 8.7001.B.4. 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 8.7001.B.4.

8.7001.B Individual Rights under the Home and Community-Based Services (HCBS) Settings Final Rule

1. Statement of Purpose, Scope, and Enforcement

a. The purpose of this Section 8.7001.B 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.

b. This Section 8.7001.B is enforced pursuant to existing procedures.

2. Basic Criteria Applicable to All HCBS Settings

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 8.7001.B.4:

i. 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.

1) 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.

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

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

4) Individuals may communicate privately with anyone of their choosing.

5) Methods of communication are not limited by the provider.

a) 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.

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

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

6) Individuals have control over their personal resources, including money and personal property. 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.

a) Provider Agencies 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.

b) A Provider Agency 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 Agency holds or manages an individual's funds, their signed Person-Centered Support Plan must:

i) Document the request or representative payee designation;

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

iii) Include the parties' agreement on the scope of managing the funds, how the Provider Agency should

handle the funds, and what they define as “reasonable amounts” under Section 25.5-10-227, C.R.S.

c) The Provider Agency 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.

ii. 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.

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

1) 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.

a) 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 8.7001.B.4.

b) 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.

c) 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 8.7001.B.4.

d) 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 8.7001.B.4. 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 8.7001.B.4.

2) 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.

iv. 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.

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

vi. 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.

vii. Each individual is afforded the opportunity to:

1) Lead the development of, and grant informed consent to, any provider-specific treatment, care, supports, or service plan;

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

3) Live and receive services in a clean, safe environment;

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

5) Be free from physical abuse and inhumane treatment;

6) Be protected from all forms of sexual exploitation;

7) Access necessary medical care which is adequate and appropriate to their condition;

8) Exercise personal choice in areas including personal style; and

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

viii. 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.

ix. 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.

3. Additional Criteria for HCBS Settings

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 8.7001.B.4:

i. 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.

1) The lease, residency agreement, or other written agreement must:

a) Provide substantially the same terms for all individuals;

b) Be in Plain Language, or if the Provider Agency/its independent Contractor cannot adjust the language, at least be explained to the individual in Plain Language;

c) 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;

d) Specify that the individual will occupy a particular room or unit;

e) Explain the conditions under which people may be asked to move or leave;

f) 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;

g) Specify the duration of the agreement;

h) Specify rent or room-and-board charges;

i) Specify expectations for maintenance;

j) 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;

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

l) Be signed by all parties, including the individual or, if within the scope of their authority, their Guardian or other Legally Authorized Representative.

2) The lease, residency agreement, or other written agreement may:

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

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

3) The lease, residency agreement, or other written agreement may not modify the individual rights protected under Sections 8.7001.B.2 and 8.7001.B.3, 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.

4) Provider Agencies 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. Provider Agencies 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.

5) 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 calendar days' notice to the individual (or, if authorized, their Guardian or other Legally Authorized Representative).

6) If an individual has not moved out after the end of a 30-day (or longer) notice period, the Provider Agency/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.

7) A Provider Agency/its independent Contractor may not require an individual who has nowhere else to live to leave the setting.

8) This Subsection 8.7001.B.3.a.i. does not apply to children under age 18.

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

1) 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 locks. 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. If an individual's lockable place for their belongings is a locker, the Provider Agency must supply a padlock and key/combination.

2) Individuals shall have choice in a roommate/housemate. Provider Agencies must have a process in place to document expectations and outline the process to accommodate choice.

3) 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.

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

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

v. 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);

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

vii. 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

viii. 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.

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 Subsection 8.7001.B.3.a.i relating to a lease or other written agreement providing protections against eviction, subject to the Rights Modification process in Section 8.7001.B.4.

c. Other Residential Settings in which no individuals receiving 24-hour residential services and supports reside are excluded from this Section 8.7001.B.3.

i. This group of settings includes, but is not limited to, homes in which no individual receives Individual Residential Service and Supports (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.

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 Subsection 8.7001.B.3.a.i relating to a lease or other written agreement providing protections against eviction and Subsection 8.7001.B.3.a.ii relating to privacy in one's living/sleeping unit, subject to the Rights Modification process in Section 8.7001.B.4.

i. 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 locks. In addition to supplying a locker, the Provider Agency must supply a padlock and key/combination.

ii. This Section 8.7001.B.3 does not require Non-Residential Settings to provide food if they are not already required to do so under other authorities. This Section 8.7001.B.3 requires Non-Residential Settings to ensure that individuals have access to their own food at any time.

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 8.7001.B.4.

4. Rights Modifications

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 8.7001.B.4.c and 8.7001.B.4.d below. Rights Modifications may not be imposed across-the-board and may not be based on the convenience of the Provider Agency/its independent Contractor. The Provider Agency/its independent Contractor 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.

b. The process set out in Sections 8.7001.B.4.c-d below applies to all Rights Modifications.

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 Agency/its independent Contractor implementing the Rights Modification must maintain a copy of the documentation:

i. The right to be modified.

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

iii. The positive interventions and supports used prior to any Rights Modification, as well as the plan going forward for the Provider Agency/its independent Contractor to support the individual in learning skills so that the modification becomes unnecessary.

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

v. A clear description of the Rights Modification that is directly proportionate to the specific assessed need. Rights of an individual receiving services may be modified only in a manner that will promote the least restriction on the individual’s rights and in accordance with rules herein.

vi. 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.

vii. An established timeline for periodic reviews of the data collected under the preceding paragraph. The Rights Modification must be reviewed and updated as necessary 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.

viii. The Informed Consent of the individual (or, if authorized, their Guardian or other Legally Authorized Representative) agreeing to the Rights Modification, as documented on a completed and signed Department-prescribed form. To be completed, the form must be filled out using Plain Language, addressed directly to the individual, and it must address only one Rights Modification. Informed Consent may not be requested or granted for a Rights Modification extending beyond the 12-month or shorter period as set out in Section 8.7001.B.4.c.vii.

ix. 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 or other approaches to prevent harm or discomfort and to mitigate any effects of the modification.

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

xi. 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.

d. Additional Rights Modification process requirements:

i. 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.

ii. Any Provider Agencies 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 8.7001.B.4, 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 Agency is satisfactory before the Case Manager enters it into their Person-Centered Support Plan.

iii. When a Rights Modification is proposed, it is reviewed by the individual, their Guardian or other Legally Authorized Representative, and the rest of the individual’s Member Identified Team and, if consented to, it is documented in the Person-Centered Support Plan.

iv. When a right has been modified, the continuing need for such modification shall be reviewed by the individual's Member Identified Team, as led by the individual or their Guardian or other Legally Authorized Representative, at a frequency decided by the team, but at least every six months.

1) Such review shall include the original reason for modification, current circumstances, success or failure of programmatic intervention, and the need for continued modification.

2) Restoration of affected rights shall occur as soon as circumstances justify.

3) If the review indicates that changes are needed to the Rights Modification, the Case Manager shall obtain a new signature on an updated Department-prescribed Informed Consent form. If the review indicates that no changes are needed, then the original signature is still valid for the remaining period (up to six months).

v. At the time a right is modified, such action if subject to Human Rights Committee review shall be referred to the Human Rights Committee for review and

recommendation. Such review shall include an opportunity for the individual or Member who is affected, Parent of a minor, Guardian or other Legally Authorized Representative, after being given reasonable notice of the meeting, to present relevant information to the Human Rights Committee.

e. Use of Restraints

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

1) Be based on an assessed need after all less restrictive interventions have been exhausted;

2) Be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights protected under Section 8.7001.B.2, consistent with the Rights Modification process in this Section 8.7001.B.4; and

3) Be compliant with any applicable waiver or CFC program.

ii. Prone Restraints are prohibited in all circumstances. Nothing in this Subsection 8.7001.B.4.e permits the use of any Restraint that is precluded by other authorities.

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

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

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

iii. Be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights protected under Section 8.7001.B.2, consistent with the Rights Modification process in this Section 8.7001.B.4, with the documentation including:

1) 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;

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

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

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

5) The individual's (or, if authorized, their Guardian's or other Legally Authorized Representative's) consent to restrictive- or controlled-egress goals for care;

6) The individual's preferences for engagement within the setting's community and within the broader community; and

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

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

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 8.7001.B.4, so long as the Provider Agency/its independent Contractor 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 8.7001.B.4 have been met.

h. When a Provider Agency proposes a Rights Modification and supplies to the Case Manager the unsigned Informed Consent form with all of the information required to be documented under this Section 8.7001.B.4, 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 8.7001.B.4.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 Agency all of 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.

8.7001.C Additional Provisions Regarding Rights and Responsibilities of Members and Other Individuals

1. Member and Other Individual Rights

a. An individual receiving services has the same legal rights and responsibilities guaranteed to all other individuals under the federal and state constitutions and federal and state laws including, but not limited to, those contained in Sections 25.5-10-201 through 2401, C.R.S., unless such rights are modified pursuant to state or federal law. Many rights of Members and other individuals and a process for modifying those rights in individual cases are set forth in Section 8.7001.B. Members and other individuals have additional rights as set forth below and elsewhere in these rules. These additional rights apply not just at HCBS Settings, but also in the context of Case Management, and unless otherwise specified, they are not subject to modification.

b. Every person has the right to 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.

c. No individual, their Family Members, Guardians, or other Legally Authorized Representatives may be retaliated against in their receipt of Case Management services or supports or direct services and supports as a result of attempts to advocate on their own behalf.

d. Each individual receiving services has the right to read or have explained in their and their family's native language any policies and/or procedures adopted by their provider(s) and their Case Management Agency.

e. The individual and the individual's Legally Authorized Representative as necessary is fully informed of the individual's rights and responsibilities.

f. The individual and/or the individual's Legally Authorized Representative participates in the development and approval of, and is provided a copy of, the individual's Person-Centered Support Plan.

g. The individual and/or the individual's Legally Authorized Representative selects service providers from among available qualified and willing providers.

h. The individual and/or the individual's Legally Authorized Representative has access to a uniform Complaint system provided for all individuals served by the Case Management Agency.

i. The individual who applies for or receives publicly funded benefits and/or the individual's Legally Authorized Representative has access to a uniform appeal process, which meets the requirements of Section 8.057 when benefits or services are denied or reduced, and the issue is appealable.

j. Members shall have the right to read or have explained any rules or regulations adopted by the Department and policies and procedures of the Case Management Agency pertaining to such people's activities and services and supports, and to obtain copies of Sections 25.5-10-201 through 24~~1~~0, C.R.S., rules, policies or procedures at no cost or at a reasonable cost in accordance with Section 24-72-205, C.R.S.

k. Members and other individuals have the right to request that an Assessment be completed even if the intake Case Management Agency staff determines otherwise. If an Assessment is requested, the Case Management Agency must complete it.

l. Members and other individuals have the right to include anyone they would like in the service and Person-Centered Support Planning process.

m. Members and other individuals have the right to be provided with support to help them direct the planning process to the maximum extent possible and to help them make informed choices and decisions.

n. Members and other individuals have the right to schedule the planning process at a time and place convenient to them.

o. Members and other individuals have the right to choose any Long-Term Services and Supports programs and services that they are eligible for. Members may only enroll in one waiver at a time.

p. Members and other individuals have the right to know in advance if services are going to be stopped.

q. Members and other individuals have the right to be provided with services and supports that do not have any potential conflict of interest with their Case Management or the development of their Person-Centered Support Plan.

2. Case Management Requirement for Preservation of Member Rights

a. Members have the right to receive Case Management services in accordance with Section 8.7201.J in the preservation of their rights.

b. If rights are not preserved by Case Management Agencies to the degree necessary, Members may engage in the Complaint process with the Agency or escalate their Complaints to the Department of Health Care Policy & Financing (HCPF) via the escalation process on the Department of Health Care Policy & Financing website and/or explained to them by their Case Manager.

3. Member and Other Individual Rights to Access the Case Management Agency

a. Members and other individuals have the right to access the Case Management Agency without physical or programmatic barriers, in compliance with the Americans with Disabilities Act, 42 U.S.C. § 12101, et seq.

b. Members and other individuals have a right to request meetings outside of the Case Management Agency office.

c. Members and other individuals have the right to be free from Discrimination and to file a Complaint with a Case Management Agency about their services without fear of retaliation. This includes if or when an advocate files a Complaint on behalf of a Member or individual.

d. Members and other individuals have the right to Person-Centered Case Management delivery. Case Management Agency functions shall be based on a person-centered model of Case Management service delivery.

4. Member Responsibilities

a. To the degree possible, each Member or Guardian is responsible to:

i. Provide accurate information regarding the individual's ability to complete Activities of Daily Living,

ii. Assist in promoting the individual's independence,

iii. Cooperate in the determination of Financial Eligibility for Medicaid,

iv. Participate in all waiver program and CFC program required activities, including but not limited to:

1) Level of Care Screen;

2) Needs Assessment;

3) Person-Centered Support Planning;

4) Monitoring, including in the Member's home; and

5) All required in-person activities except in cases of natural disaster, pandemic or other emergency

v. Notify the Case Manager within thirty (30) calendar days or as soon as possible when:

1) There are changes in the individual's support system, medical, physical or psychological condition or living situation including any hospitalizations, emergency room admissions, or placement in a nursing home or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID),

2) The individual has not received an HCBS waiver service during one (1) month,

3) There are changes in the individual's care needs,

4) There are problems with receiving HCBS Waiver Services,

5) There are changes that may affect Medicaid Financial Eligibility, including changes in income or assets,

6) There are changes in legal status, such as guardianship or Legally Authorized Representative.

5. Use of a Long-Term Services and Supports Representative

a. People who are eligible for services and supports and their Legally Authorized Representative(s) shall have the opportunity at the time of enrollment and at each annual review of the Person-Centered Support Plan to designate a Long-Term Services and Supports Representative to be included in their Member Identified Team. The designation of a Long-Term Services and Supports Representative must occur with informed consent of the person receiving services or, if applicable, their Legally Authorized Representative.

b. Such designation shall be in writing and shall specify the duration of the Long-Term Services and Supports Representative's involvement and specific authority in assisting the Member in acquiring or utilizing Long-Term Services and Supports and in protecting their rights.

c. The written designation of a Long-Term Services and Supports Representative shall be maintained in the record of the person receiving services.

d. The person receiving services or, if applicable, their Legally Authorized Representative may withdraw their designation of a Long-Term Services and Supports Representative at any time.

8.7200 Case Management Agency Requirements

8.7200.B. Definitions

Unless otherwise specified, the following definitions apply throughout Sections 8.7000-7500.

1-A. Business Day means any day in which the state is open and conducting business, but shall not include Saturday, Sunday, or any day in which the state observes one of the holidays listed in Section 24-11-101(1), C.R.S.

9. Conflict Free Case Management means Members enrolled in any Long-Term Services and Supports and/or Community First Choice (CFC) programs and/or Home and Community-Based Services waivers ~~and/or Community First Choice (CFC)~~ must receive direct ~~Home and Community-Based~~ Services and Case Management from separate entities.

19. Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities. Long term Services and Supports includes but is not limited to long term care such as nursing facility care as part of the standard Medicaid benefit package, Community First Choice (CFC) services, and Home and Community-Based Services provided under waivers granted by the Federal government.

21. Long Term Services and Supports (LTSS) Program means any of the following: publicly funded programs, Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU), ~~and~~ Adult Long-Term Home Health (LTHH), and Community First Choice (CFC).

22. Member means as defined in 8.7001.A.8-B.

24-A. Performance and Quality Review means a review conducted by the Department or its contractor at any time but no less than the frequency as specified in the approved waiver application. The review shall include a review of required case management services performed by the agency to ensure quality and compliance with all requirements.

26-A. Prior Authorization Requests (PAR) means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.26-B. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the Member's obligation (payment) for the payment of residential services.

27-A. Regional Center means as defined at § 24-10.5-102, C.R.S.27-B. Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Member's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Members in each level, and projected utilization.

28-A. Supports Intensity Scale (SIS) means as defined at 8.7100.A.62.

28-B. Support Level means as defined at 8.7100.A.63.

29. Target Group Criteria means as defined at 8.7100.A.63-A.

29-A. Targeted Case Management (TCM) means case management services provided to Members enrolled in the HCBS waivers or CFC in accordance with Section 8.760 et seq.,

8.7201 Case Management Agency Overall Requirements

8.7201.F Staffing Patterns

3. Case Management Agencies shall maintain staffing patterns in accordance with Department prescribed best practices for Long-Term Services and Supports Case Manager-level caseloads for all Targeted Case Management Activities and shall comply with all contractual requirements.

a. Case Management Agency shall not exceed the best practice standards for HCBS waiver or CFC caseload sizes without written approval from the Department.

8.7202 Functions of A Case Management Agency

8.7202.C Nursing Facility Admission and Discharge

4. A Case Manager may determine that an individual is eligible to receive Waiver or CFC Services while the individual resides in a nursing facility when the individual meets the eligibility criteria as established at Section 8.7100 and the individual requests to transition out of the nursing facility.

5. A Case Manager may determine that an individual is eligible to receive Waiver or CFC Services while the individual resides in a nursing facility when the individual meets the eligibility criteria as established at Sections 8.400, and 8.7100 and the individual requests to transition out of the nursing facility.

8.7202.E Level of Care Determination

1. The Level of Care Screen shall be used to establish a Member's Level of Care.

2. At the time of completing the Level of Care Screen, unless the individual opposes community living, the Case Manager shall provide options counseling on community-based services to the individual to determine if they desire to live in the community with additional support.

3. The Case Management Agency shall complete the Level of Care Screen within the following time frames:

a. For an individual who is not being discharged from a hospital or a nursing facility, the individual Assessment shall be completed and documented in the Department prescribed technology system within 10 working days after receiving confirmation that the Medicaid application has been received by the county department of social services, unless a different time frame specified below applies.

b. The Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility for a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility.

c. For a resident who is being admitted to the nursing facility from the hospital, the Case Management Agency shall complete and document the Assessment, including a Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen within two (2) working days after notification.

i. For Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen regulations, Section 8.401.18

d. For an individual who is being transferred from a nursing facility to ~~an~~ CFC or an HCBS program or between nursing facilities, the Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility.

e. For an individual who is being transferred from a hospital to CFC or an HCBS program the Case Management Agency shall complete and document the Assessment within two (2) working days after notification from the hospital.

4. Under no circumstances shall the start date for Functional Eligibility based on the Level of Care Screen be backdated by the Case Manager.

5. The Case Management Agency shall complete and document the Level of Care Screen for Long-Term Services and Supports Programs, in accordance with Section 8.401.1. Under no circumstances shall late PAR revisions be approved by the State or its agent.

6. The Case Management Agency shall assess the individual's functional status face-to-face in the location where the person currently resides. Upon Department approval, Assessment may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g. natural disaster, pandemic, etc.).

7. The Case Management Agency shall conduct the following activities when completing a Level of Care Screen of an individual seeking services:

a. Obtain diagnostic information in the manner prescribed by the Department from the individual's medical provider for individuals in nursing facilities, ICF-IID, CFC, or HCBS waivers.

b. Determine the individual's functional capacity during an assessment, with observation of the individual and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section 8.401.1.

c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.15.

d. Determine the need for Long-Term Services and Supports on the Level of Care Screen during the assessment.

e. For CFC and HCBS Programs and admissions to nursing facilities from the community, the original Level of Care Screen and Person-Centered Support Plan copy shall be sent to entities or persons of the Member's choosing. If changes to the individual's condition

occur which significantly change the payment or services amount, a copy of the Person-Centered Support Plan must be sent to the Provider Agency, and a copy is to be maintained in the Member's record.

f. When the Case Management Agency assesses the individual's functional capacity on the Level of Care Screen, it is not an Adverse Action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into a Long-Term Services and Supports Program by the Case Management Agency based on the Level of Care Screen for Functional Eligibility. The appeal process is governed by the provisions of Section 8.057.

8.7202.J Person-Centered Support Coordination

1. Service and support coordination shall be the responsibility of the Case Management Agencies. Service and support coordination shall be provided in partnership with the Member receiving services, the Parents of a minor, and legal Guardians.

a. The Member shall designate a Member Identified Team which may include but not be limited to: a LTSS Representative, family members, or individuals from public and private agencies to the extent such partnership is requested by the Member.

9. Individuals and/or their Guardians and other Legally Authorized Representatives, as appropriate, who enroll in HCBS Waiver Services or CFC Services shall have the freedom to choose from qualified Provider Agencies in accordance with Section 8.7400, as applicable.

12. Case Managers shall follow all documented policy and operational guidance from the Department for Case Management services including but not limited to:

a. Home modification

b. Vehicle modification

c. Organized Health Care Delivery System

d. Consumer-Directed Attendant Supports Services

e. In-Home Support Services

f. Nursing Facilities

g. Transition Services

h. Long Term Home Health

i. Private Duty Nursing

8.7202.R Denials/Discontinuations/Adverse Actions

1. Individuals seeking or receiving services shall be denied or discontinued from services provided pursuant to publicly funded programs for which the Case Management Agency provides case management services if they are determined ineligible for any of the reasons below. Individuals shall be notified of any of the adverse actions and appeal rights as follows:

a. Financial Eligibility

i. The eligibility enrollment specialist from the county department of social services shall issue to the Member a Long Term Care Waiver Program Notice of Action (LTC-803) regarding denial or discontinuation of services for reasons of Financial Eligibility which shall inform the individual of appeal rights in accordance with Section 8.057.

ii. If the individual or Member is found to be financially ineligible for HCBS or Long-Term Services and Supports benefits, the Case Management Agency shall issue to the Member a Long Term Care Waiver Program Notice of Action (LTC-803) that informs the individual of their appeal rights in accordance with Section 8.057. The Case Manager shall not attend the appeal hearing for a denial or discontinuation based on Financial Eligibility, unless subpoenaed, or unless requested by the Department.

b. Functional Eligibility and Target Group

i. The Case Management Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Long-Term Care Waiver Program Notice of Action and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual does not meet the Functional Eligibility requirement for HCBS waiver and Long-Term Services and Supports Programs or nursing facility admissions or CFC Level of Care requirements outlined in Section 8.7604; or

2) The individual does not meet the Target Group Criteria as specified by the HCBS waivers; or

3) The individual failed to submit the required paperwork, documents or any other part of the eligibility criteria and/or application within 90 days from Level of Care Screen.

c. Receipt of Services

i. The Case Management Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Long-Term Care Waiver Program Notice of Action and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual has not received ~~long-term services or supports~~an HCBS Waiver service for one calendar month, ~~unless those services or supports are provided through CFC~~;

2) The individual does not keep or schedule an appointment for Assessment or monitoring two (2) times in a one month consecutive period as required by these regulations.

4. The Case Management Agency shall provide the Long-Term Care Waiver Program Notice of Action form to Applicants and individuals within 11 business days regarding their appeal rights in accordance with Section 8.057 et seq. when

   a. The individual or Applicant is determined to not have a Developmental Disability,

   b. The individual or Applicant is found ineligible for Long-Term Services and Supports.

   c. The individual or Applicant is determined eligible or ineligible for placement on a waiting list for Long-Term Services and Supports,

   d. An adverse action occurs that affects the individual's or Applicant's waiver enrollment status,

   e. The individual or Applicant voluntarily withdraws.

8. The Case Manager shall follow procedures to close the individual's case in the Information Management System within one (1) business day of discontinuation for all CFC or HCBS Programs

8.7202.Z Targeted Case Management Activity Billing and Payment Liability

1. Billing:

   a. Claims are reimbursable only when supported by the following documentation:

      i. The name of the individual;

      ii. The date of the activity;

      iii. The nature of the activity including whether it is direct or indirect contact with the individual;

      iv. The content of the activity including the relevant observations, Assessments, findings;

      v. Outcomes achieved, and as appropriate, follow up action;

      vi. For HCBS waiver or CFC programs, documentation required pursuant to Sections 8.519 and 8.760.

   b. Claims are subject to a post-payment review by the Department. If the Department identifies an overpayment or a claim reimbursement not in compliance with requirements, the amount reimbursed shall be subject to reversal of claims, recovery of the amount

reimbursed, or the Case Management Agency may be subject to suspension of payments.

c. Targeted Case Management services consist of facilitating enrollment; locating, coordinating, and monitoring Long-Term Services and Supports services; and coordinating with other non waiver or non-CFC funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources. The individual does not need to be physically present for this service to be performed if it is done on the individual's/Member's behalf.

d. TCM services provided to Members enrolled in HCBS waiver programs or CFC are to be reimbursed based on the Department's TCM Fee Schedule.

e. TCM providers shall record what documentation exists in the log notes and enter necessary documentation into the Department prescribed system as required by the Department.

i. Case Management Agencies shall document all targeted Case Management services and meet the following criteria:

1) All targeted Case Management services must be documented in the Department's system within 10 business days of the activity and prior to submitting a claim for reimbursement.

2) Documentation must be specific to the Member and clearly and concisely detail the activity completed.

3) Documentation must specify the Member's preference for in-person or virtual for monitoring contacts in adherence with Department direction and requirements.

4) The use of mass email communication, robotic and/or automatic voice messages cannot be used to replace the Case Management Agencies required Case Management services or any billable targeted Case Management service.

e. Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at 42 C.F.R. § 447.205(d) and shall be based upon a market-based research and standards.

f. TCM services may not be claimed prior to the first day of enrollment into an eligible program nor prior to the actual date of eligibility for Medicaid benefits.

2. Exclusions

a. Case Management services provided to any individuals enrolled in the following programs are not billable as Targeted Case Management services as specified in Section 8.7202.Z:

i. Persons enrolled in a Home and Community-Based Services waiver or CFC not included as an eligible HCBS service as described in Sections 8.7000-8.7100 and 8.7500.

ii. Persons residing in a Class I nursing facility.

iii. Persons residing in an Intermediate Care Facility for the Intellectually Disabled (ICF-ID).

3. Payment Liability

a. Failure to prepare the service plan and prior authorization or failure to submit the service plan forms in accordance with Department policies and procedures shall result in the reversal and recovery of reimbursement for services authorized retroactive to the first date of service. The Case Management Agency and/or providers may not seek reimbursement for these services from the Member.

b. If the Case Management Agency causes an individual enrolled in HCBS Waiver Services to have a break in payment authorization, the Case Management Agency shall ensure that all services continue and shall be solely financially responsible for any losses incurred by Provider Agencies until payment authorization is reinstated.

8.7202.CC PRIOR AUTHORIZATION REQUESTS (PAR)

1. All Home and Community-based Services must be prior authorized by the Department or its agent.

a. The Case Manager shall complete and submit the Department's approved PAR form within one calendar month of determination of eligibility for a waiver or CFC.

2. All units of service requested shall be listed on the Person-Centered Support Plan.

3. The first date for which services may be authorized is the latest date of the following:

a. The financial eligibility start date, as determined by the financial eligibility site.

b. The assigned start date on the certification page of the Department approved assessment tool.

c. The date, on which the Member's parent(s) and/or legal guardian signs the Person-Centered Support Plan or Intake form, as prescribed by the Department, agreeing to receive services.

4. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Department approved assessment tool.

5. The Case Manager shall submit a revised PAR if a change in the Person Centered Support Plan results in a change in services.

6. The revised Person Centered Support Plan shall list the service being changed and state the reason for the change. The services being revised, as indicated in the revised Person Centered Support Plan, plus all services not revised, as shown on the Plan prior to revision, shall be entered on the revised PAR.

7. Revisions to the Person Centered Support Plan requested by providers after the end date on a PAR shall be disapproved.

8. If the revisions to the Person Centered Support Plan result in a decrease in services without the Member's parent's(s) and/or legal guardian's agreement, the Case Manager shall notify the Member's parent(s) and/or legal guardian of the adverse action and appeal rights using the appropriate forms, timelines and process as described in 8.7202.R.

9. REIMBURSEMENT

a. Providers shall be reimbursed at the lower of:

i. Submitted charges; or

ii. The fee schedule amount as determined by the Department.

b. Claims for services are not reimbursable if:

i. Services are not consistent with the Member's documented medical condition and functional capacity;

ii. Services are not medically necessary or are not reasonable in amount, scope, frequency, and duration;

iii. Services are duplicative of other services included in the Member's Support Plan;

iv. The Member is receiving non-Medicaid funds to purchase services; or

v. Services total more than 24 hours per day of care.

10. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

11. Payment for HCBS waiver and/or CFC services is also conditional upon:

a. The Member's eligibility for HCBS waiver and/or CFC services;

b. The provider's certification status, if appropriate; and

c. The submission of claims in accordance with proper billing procedures.

12. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulations and medically necessary.

13. Services requested on the PAR shall be supported by information on the Person Centered Support Plan and written documentation of the Member's current monthly income from the income maintenance technician.

14. The PAR start date shall not precede the start date of HCBS waiver or CFC eligibility.

15. The PAR end date shall not exceed the end date of the HCBS waiver or CFC eligibility certification period.

8.7400 Home and Community-Based Services Provider Agency Requirements

8.7401 Statement of Purpose and Scope

A. The purpose of this Section 8.7400 is to outline requirements for Home and Community-Based Services (HCBS) Provider Agencies. These rules apply to all HCBS waivers and Community First Choice.

8.7500 HCBS Benefits and Services Requirements

8.7501 Statement of Purpose and Scope

A. The purpose of this Section 8.7500, et seq. is to outline the Waiver Benefit and Service and CFC Benefit requirements under the Home and Community-Based Services (HCBS) Waivers and Community First Choice (CFC).

8.7502 Definitions: Unless otherwise specified, the following definitions apply throughout Sections 8.7000-8.7500.

A. Acquisition, Maintenance, and Enhancement of Skills (AME) means functional skills training necessary for the individual to accomplish ADLs and~~,~~ IADLs~~, and health-related tasks~~. AME is a task available through Personal Care and Homemaker.

~~A~~B. Activities of Daily Living (ADLs) is as defined at Section 8.7100.A.1.

~~B~~C. Adaptive Equipment means one or more devices used to assist with completing Activities of Daily Living.

~~C~~D. Case Management Agency is as defined ~~as~~ at Section 8.7100.A.8.

~~D~~E. Case Manager is as defined at Section 8.7200.B.5.

F. Community First Choice (CFC) is as defined at Section 8.7001.A.1-A.

G. CFC Benefit means services defined in the current federally approved CFC State Plan Amendment and does not include other Medicaid State Plan benefits or Waiver Benefits.

~~E~~H. Congregate Facility is as defined at Section 8.7100.A.12.

~~F~~I. Department is as defined in Section 8.7200.B.14.

~~G~~J. Developmental Disability is as defined at Section 8.7100.A.23.

K. Direct Care Services Calculator means a tool used by a Case Manager or vendor to indicate the number of hours of Attendant services a Member needs for each covered personal care services, homemaker services, and health maintenance activities. For children, Case Managers must utilize the Age-Appropriate Guidelines provided by the Department.

~~H~~L. Direct Care Worker is as defined at Section 8.7402.F.

~~I~~M. Durable Medical Equipment is as defined at Section 8.580.

~~J~~N. Early And Periodic Screening, Diagnosis and Treatment (EPSDT) is as defined at Section 8.280.1.

~~K~~O. Family Member means any person or relative related to the Member by blood, marriage, or adoption, or by common law as determined by a court of law.

~~L~~P. Financial Eligibility is as defined at Section 8.7100.A.28.

~~M~~Q. Functional Eligibility is as defined at Section 8.7100.A.29.

~~N~~R. Home and Community-Based Services (HCBS) waiver is as defined at 8.7100.A.35

~~O~~S. Intellectual and Developmental Disability is defined at § 25.5-6-403(3.3)(a), C.R.S. and 8.7100.A.40.

~~P~~T. Instrumental Activities of Daily Living (IADLs) means activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework and communication.

~~Q~~U. Licensed Medical Professional (LMP) means the primary care provider of the Member, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN). License Medical Professional practices shall adhere to the Colorado Medical Practice Act or the Colorado Nurse Practice Act, as applicable to the professional licensure category.

~~R~~V. Legally Authorized Representative is as defined at 8.7001.A.7.

W. Legally Responsible Person means any person who has legal responsibility to care for another person such as the parent or guardian of a minor child or the member's spouse.

~~S~~X. Long Term Services and Supports Representative is as defined at Section 8.7001.A.8.

~~T~~Y. Member is as defined at 8.7001.A.8-B.

~~U~~Z. Person-Centered Support Plan is as defined at 8.7001.A.11.

~~V.~~AA, Prior Authorization Request (PAR) is as defined at 8.7202.B.

~~W~~BB. Provider Agency is as defined at 8.7001.A.12-B.

~~X~~CC. Provider Care Plan is as defined at 8.7402.T.

~~Y~~DD. Restraint is as defined at Section 8.7001.A.15.

~~Z~~EE. Universal Precautions means a system of infection control that prevents the transmission of communicable diseases. Precautions include, but are not limited to, disinfecting of instruments, isolation and disinfection of the environment, use of personal protective equipment, hand washing, and proper disposal of contaminated waste.

~~AA~~FF. Waiver Benefit is as defined at section 8.7200.B.31

~~BB~~GG. Waiver Service is as defined at 8.7100.A.68.

8.7515 Consumer Directed Attendant Support Services (CDASS)

8.7515A CDASS Eligibility

1. CDASS is a covered benefit available to Members enrolled in CFC.~~one of the following Home and Community Based Services (HCBS) waivers:~~

~~a. Brain Injury Waiver~~

~~b. Community Mental Health Supports Waiver~~

~~c. Complementary and Integrative Health Waiver~~

~~d. Elderly, Blind, and Disabled Waiver~~

~~e. Supported Living Services Waiver~~

8.7515.B CDASS Definitions

1. Adaptive Equipment is as defined at 8.7502.~~B~~

2. Allocation means the funds determined by the Case Manager in collaboration with the Member and made available by the Department through the Financial Management Service (FMS) Contractor for Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option.

3. Attendant means the individual who meets qualifications in 8.7515.I who provides CDASS as described in Section 8.7515.D and is hired by the Member or Authorized Representative through the FMS Contractor.

4. Attendant Support Management Plan (ASMP) means the documented plan described in Section 8.7515.F, detailing management of Attendant support needs through CDASS.

5. Authorized Representative (AR) means an individual designated by the Member or the Member's legal Guardian, if applicable, who has the judgment and ability to direct CDASS on a Member's behalf and meets the qualifications contained in Sections 8.7515.G and 8.7515.H.

6. Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that empowers Members to direct their care and services to assist them in accomplishing Activities of

Daily Living when included as a ~~Waiver~~ CFC Benefit. CDASS benefits may include assistance with health maintenance, personal care, and homemaker activities.

7. CDASS Person-Centered Support Plan Year Allocation means the funds determined by the Case Manager to be required to cover the cost of Attendant services, made available by the Department for the period the Member is approved to receive CDASS within the annual support plan year.

~~8. CDASS Task Worksheet means a tool used by a Case Manager to indicate the number of hours of Attendant services a Member needs for each covered CDASS personal care services, homemaker services, and health maintenance activities.~~

~~9. CDASS Training means the required CDASS training and comprehensive assessment provided by the Training and Support Contractor to a Member or Authorized Representative.~~

8. CDASS Coaching means technical support provided to Members/Authorized Representatives by the Training and Support Contractor for skills related to allocation and budget management, planning and organizing attendant services, managing employer of record responsibilities, communication skills, assessing resources, care quality, and working with the Financial Management Services vendor. The Department may mandate CDASS coaching as outlined in section 8.7514.N.2.

9. CDASS Orientation means the required orientation for CDASS members and Authorized Representatives that includes, but is not limited to: an overview of the program, member/and or authorized rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety, and prevention strategies, managing emergencies, and working with the Financial Management Services vendor.

10. CDASS Training is voluntary and supplemental to CDASS Orientation and CDASS Coaching. Including additional support surrounding the topics covered in Orientation and Coaching, CDASS Training topics may include, but are not limited to, Electronic Visit Verification compliance, employer of record requirements, and self-advocacy techniques for additional self-directed services needs.}

11. Electronic Visit Verification (EVV) means the use of technology, including mobile device technology, telephony, or Manual Visit Entry, to verify the required data elements related to the delivery of a service mandated to be provided using EVV by the "21st Century Cures Act," P.L. No. 114-255, or Section 8.001.

12~~1~~. Extraordinary Care means a service which exceeds the range of care a Family Member would ordinarily perform in a household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the Member and avoid institutionalization.

13~~2~~. Family Member means any person related to the Member by blood, marriage, adoption, or common law as determined by a court of law.

14~~3~~. Financial Eligibility means the Health First Colorado Financial Eligibility criteria based on Member income and resources.

154. Financial Management Services (FMS) Contractor means an entity contracted with the Department and chosen by the Member or Authorized Representative to complete employment-related functions for CDASS Attendants and to track and report on individual Member CDASS Allocations.

165. Fiscal/Employer Agent (F/EA) provides FMS by performing payroll and administrative functions for Members receiving CDASS benefits. The F/EA pays Attendants for CDASS services and maintains workers' compensation policies on the Member-employer's behalf. The F/EA withholds, calculates, deposits and files withheld federal income tax and both Member-employer and Attendant-employee Social Security and Medicare taxes.

176. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and Support Contractor or the FMS Contractor, and which includes documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language.

187. Notification means a communication from the Department or its designee concerning information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS website, Member account statements, Case Manager contact, or FMS Contractor contact.

198. Stable Health means a medically predictable progression or variation of disability or illness.

2019. Training and Support Contractor means the organization contracted by the Department to provide orientation, coaching, training, and customer service for self-directed service delivery options to Members, Authorized Representatives, and Case Managers.

8.7515.C CDASS Member Eligibility

1. To be eligible for the CDASS delivery option, the Member shall meet the following eligibility criteria:

   a. Choose the CDASS delivery option.

   b. Be enrolled in CFC ~~a Medicaid program approved to offer CDASS~~.

   c. Demonstrate a current need for covered Attendant support services.

   ~~d. Document a pattern of Stable Health indicating appropriateness for community-based services and a predictable pattern of CDASS Attendant support.~~

   d~~e~~. Provide a statement, at ~~an interval determined by the Department~~enrollment and following any change in condition, from the Member's primary care physician, physician assistant, or advanced practice nurse, attesting to the Member's ability to direct their care with sound judgment or the ability of a required AR to direct the care on the Member's behalf.

   e~~f~~. Members under the age of 18 are not required to provide a statement from their primary care physician as outlined in 8.7515.C.1.d and are required to have an AR.

   f. Complete all aspects of the Attendant Support Management Plan (ASMP) and ~~training~~ orientation and demonstrate the ability to direct care or have care directed by an Authorized Representative (AR).

i. Member ~~training~~ orientation obligations

1) Members and ARs who have ~~received training~~ completed orientation through the Training and Support Contractor in the past two years or utilized CDASS in the previous six months may receive a modified ~~training~~ orientation to begin or resume CDASS. A Member who was terminated from CDASS due to a Medicaid Financial Eligibility denial that has been resolved may resume CDASS without attending ~~training~~ orientation if they received CDASS in the previous six months.

8.7515.D CDASS Inclusions and Covered Services

1. Covered services shall be for the benefit of the Member only and not for the benefit of other persons.

2. Services include:

   a. Homemaker services as described at Section 8.7527.

   b. Personal Care services as described at Section 8.7538.

   c. Health Maintenance Activities services as described at Section 8.7523.

8.7515.E CDASS Exclusions and Limitations

1. CDASS Attendants shall not perform services and shall not receive reimbursement for services performed:

   a. While Member is admitted to a nursing facility, hospital, a long-term care facility or is incarcerated;

   b. Following the death of the Member;

2. The Attendant shall not be reimbursed to perform tasks at the same time a Member is concurrently receiving a waiver service or CFC service in which a provider is required to perform the same task during the provision of a billed service. ~~The Attendant shall not be reimbursed to perform tasks at the time a Member is concurrently receiving a waiver service in which the provider is required to perform the tasks in conjunction with the waiver service being rendered.~~

3. Companionship is not a covered CDASS service.

4. Billing for travel time is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Employers must follow all Department of Labor and Employment guidelines on time worked.

8.7515.F CDASS Attendant Support Management Plan

1. The Member/Authorized Representative (AR) shall develop a written Attendant Support Management Plan (ASMP) after completion of ~~training~~ orientation but prior to the start date of services, which shall be reviewed by the Training and Support Contractor and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date to the Financial Management Services (FMS) Contractor. The Attendant Support Management Plan shall be completed following initial ~~training~~ orientation and ~~retraining~~

mandatory coaching and shall be modified when there is a change in the Member's needs. The plan shall describe the Member's:

a. Attendant support needs;

b. Plans for locating and hiring Attendants;

c. Plans for handling emergencies;

d. Assurances and plans regarding direction of CDASS Services, as described at Sections 8.7515.G; 8.7523.C; 8.7528.C; and 8.7538.C as applicable;

e. Plans for budget management within the Member's Allocation;

f. Designation of an AR, if applicable; and

g. Designation of regular and back-up employees proposed or approved for hire.

2. If the ASMP is disapproved by the Case Manager, the Member or AR has the right to Case Management Agency review of the disapproval. The Member or AR shall submit a written request to the Case Management Agency stating the reason for the review and justification of the proposed ASMP. The Member's most recently approved ASMP shall remain in effect while the review is in process.

8.7515.G CDASS Member/AR Responsibilities

1. Member/AR shall complete the following responsibilities for CDASS management:

a. Complete ~~training~~ orientation provided by the Training and Support Contractor. Members who cannot complete ~~training~~ orientation shall designate an AR.

b. Complete and submit an ASMP at initial enrollment when a Member's Allocation changes by 25% or more and whenever required based on the Member's needs.

c. Determine wages for each Attendant not to exceed the rate established by the Department.

d. Determine the required qualifications for Attendants.

e. Recruit, hire and manage Attendants.

f. Complete employment reference checks on Attendants.

g. Train Attendants to meet the Member's needs. When necessary to meet the goals of the ASMP, the Member/AR shall verify that each Attendant has been or will be trained in all necessary health maintenance activities before the Attendant provides direct care to the Member.

h. Terminate Attendants when necessary, including when an Attendant is not meeting the Member's needs.

i. Operates as the Attendant's legal employer of record.

j. Complete necessary employment-related functions through the Financial Management Services (FMS) Contractor, including hiring and termination of Attendants and employer-related paperwork necessary to obtain an employer tax ID.

k. Ensure all Attendant employment documents have been completed and accepted by the FMS Contractor prior to beginning Attendant services.

l. Follow all relevant laws and regulations applicable to the supervision of Attendants.

m. Explain the role of the FMS Contractor to the Attendant.

n. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation. Services that exceed the Member's monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the Member or AR for reimbursement through the FMS Contractor unless prior approval is obtained from the Department or its designee.

o. Authorize Attendant to perform services allowed through CDASS.

p. Ensure all Attendants required to utilize Electronic Visit Verification (EVV) are trained and complete EVV for services rendered. Timesheets shall reflect time worked and capture all required data points to maintain compliance with Section 8.001, et seq.

q. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and Member/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS.

r. Review and submit approved Attendant timesheets to the FMS by the established timelines for submission of timesheets for Attendant reimbursement.

s. Authorize the FMS Contractor to make any changes in the Attendant wages.

t. Understand that misrepresentations or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. Member/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS Contractor.

u. Complete and manage all paperwork and maintain employment records.

v. Select an FMS Contractor upon enrollment into CDASS.

2. Member/AR responsibilities for Verification:

a. Sign and return a responsibilities acknowledgement form for activities listed in Section 8.7515.G to the Case Manager.

3. Members utilizing CDASS have the following rights:

a. To receive training on managing CDASS.

b. To receive program materials in accessible format.

c. To receive advance Notification of changes to CDASS.

d. To participate in Department-sponsored opportunities for input.

e. To transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and Referral process.

f. To request a Reassessment if the Member's level of service needs have changed.

g. To revise the ASMP at any time with Case Manager approval.

8.7515.H CDASS Authorized Representatives (AR)

1. A person who has been designated as an AR shall submit an AR designation affidavit attesting that he or she:

   a. Is at least eighteen years of age;

   b. Has known the eligible person for at least two years;

   c. Has not been convicted of any crime involving exploitation, abuse, or assault on another person; and

   d. Does not have a mental, emotional, or physical condition that could result in harm to the Member.

2. CDASS Members who require an AR may not serve as an AR for another CDASS Member.

3. An AR shall not receive reimbursement for CDASS AR services and shall not be reimbursed as an Attendant for the Member they represent.

4. An AR must comply with all requirements contained in Section 8.7515.G.

5. An AR who has failed to meet the responsibilities of an AR as outlined in 8.7514.N for a member will be removed as the AR and cannot become or continue to be an AR for another member.

8.7515.I CDASS Attendants

1. Attendants shall be at least 16 years of age and demonstrate competency in caring for the Member to the satisfaction of the Member/Authorized Representative (AR).

   a. Minor attendants ages 16 to 17 will not be permitted to operate floor-based vertical powered patient/resident lift devices, ceiling-mounted vertical powered patient/resident lift devices, and powered sit-to-stand patient/resident lift devices (lifting devices).

   b. ~~Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more Members collectively.~~ Attendants may not be reimbursed for more than sixteen (16) hours of care per day for one or more members collectively.

   c. An AR shall not be employed as an Attendant for the same Member for whom they are an AR.

   d. Attendants must be able to perform the tasks on the Attendant Support Management Plan (ASMP) they are being reimbursed for and the Member must have adequate Attendants to assure compliance with all tasks on the ASMP.

   e. Attendant timesheets submitted for approval must be accurate and reflect time worked.

f. Attendants shall not misrepresent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse.

g. Attendants shall not have had their license as a nurse or certification as a nurse aide suspended or revoked or their application for such license or certification denied.

h. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the Member/AR not to exceed the amount established by the Department. The Financial Management Services (FMS) Contractor shall make all payments from the Member's Allocation under the direction of the Member/AR within the limits established by the Department.

i. Attendants are not eligible for hire if their background check identifies a conviction of a crime that the Department has identified as a high-risk crime that can create a health and safety risk to the Member. A list of high-risk crimes is available through the Department, Training and Support Contractor and FMS Contractor.

j. Attendants may not participate in Member orientation or coaching~~training~~ provided by the Training and Support Contractor. Members may request to have their Attendant, or a person of their choice, present to assist them during the ~~training~~ session based on their personal assistance needs. Attendants may not be present during the budgeting portion of the ~~training~~orientation or coaching.

8.7515.J CDASS Financial Management Services (FMS)

1. FMS Contractor shall be responsible for the following tasks:

a. Collect and process timesheets submitted by attendants within agreed-upon timeframes as identified in FMS Contractor materials and websites.

b. Conduct payroll functions, including withholding employment-related taxes such as workers' compensation insurance, unemployment benefits, withholding of all federal and state taxes, and compliance with federal and state laws regarding overtime pay and minimum wage.

c. Distribute paychecks in accordance with agreements made with Member/Authorized Representative (AR) and timelines established by the Colorado Department of Labor and Employment.

d. Submit authorized claims for CDASS provided to an eligible Member.

e. Verify Attendants' citizenship status and maintain copies of I-9 documents.

f. Track and report utilization of Member Allocations.

g. Comply with Department regulations and the FMS Contractor contract with the Department.

h. Maintain compliance with Electronic Visit Verification (EVV) requirements as defined under Section 8.001 et seq. and 8.7514 et seq., including the provision of an EVV system for Members and their attendants to collect and maintain data that verifies when CDASS services have occurred.

2. In addition to the requirements set forth at Section 8.7.515.J.1, the FMS Contractor operating under the Fiscal/Employer Agent (F/EA) model shall be responsible for obtaining designation as a Fiscal/Employer Agent in accordance with Section 3504 of the Internal Revenue Code, 26 U.S.C § 2504 (20243).

~~This statute is hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E 17th Ave, Denver, CO 802031570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.~~

8.7.515.K CDASS Selection of Financial Management Services (FMS) Contractor

1. The Member/Authorized Representative (AR) shall select an FMS ~~Contractor~~ from the ~~Contractor~~ list of FMS contracted with the Department at the time of enrollment.

2. The Member/AR may select a new FMS ~~Contractor~~ during the designated open enrollment periods. The Member/AR shall remain with their selected FMS ~~Contractor~~ until the transition to the new FMS Contractor is completed.

8.7.515.L CDASS Start of Services

1. The CDASS start date shall not occur until all of the requirements contained in Sections 8.7.515.C, 8.7.515.F, 8.7.515.G, 8.7.515.H have been met.

2. The Case Manager shall approve the Attendant Support Management Plan (ASMP), establish a service period, submit a Prior Authorization Request (PAR) and receive a Prior Authorization Request (PAR) approval before a Member is given a start date and may begin CDASS.

3. The FMS Contractor shall process the Attendant's employment packet within the Department's prescribed timeframe and ensure the Member has a minimum of two approved Attendants prior to starting CDASS. The Member must maintain employment relationships with two Attendants while participating in CDASS.

4. The FMS Contractor will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS Contractor provides the Member/Authorized Representative (AR) with employee numbers and confirms Attendants' employment status.

5. If a Member is transitioning from a hospital, nursing facility, or HCBS Agency services, the Case Manager shall coordinate with the discharge coordinator to ensure that the Member's discharge date and CDASS start date correspond.

8.7.515.M CDASS Service Substitution

1. Once a start date has been established for CDASS, the Case Manager shall establish an end date and discontinue the Member from any other Medicaid-funded Attendant support including ~~Long-Term Home Health,~~ In-Home Support Services, homemaker services, and personal care services effective as of the start date of CDASS.

2. Case Managers shall not authorize Prior Authorization Requests (PARs) with concurrent payments for CDASS and other waiver service delivery options for Personal Care services, Homemaker services, and Health Maintenance Activities for the same Member.

3. Members may receive up to 60 days of Medicaid Acute Home Health services directly following acute episodes as defined by 8.520.4.C.1.c. Members are permitted to utilize Long Term Home Health and Private Duty Nursing in conjunction with CDASS so long as the services are not utilized concurrently and are not duplicative of the services received through CDASS. ~~provided through Long Term Home Health are not duplicative of the services received through CDASS~~. CDASS service plans shall be modified to ensure no duplication of services.

4. Members may receive Hospice services in conjunction with CDASS services. CDASS service plans shall be reviewed and may be modified to ensure no duplication of services.

8.7515.N CDASS Failure to Meet Member/Authorized Representative (AR) Responsibilities

1. If a Member/AR fails to meet their CDASS responsibilities, the Member may be terminated from CDASS. Prior to a Member being terminated from CDASS the following steps shall be taken:

   a. Mandatory ~~retraining~~ coaching conducted by the contracted Training and Support Contractor.

   b. Required designation of an AR if one is not in place, or mandatory re-designation of an AR if one has already been assigned.

2. Actions requiring ~~retraining~~mandatory coaching, or appointment or change of an AR include any of the following:

   a. The Member/AR does not comply with CDASS program requirements including service exclusions.

   b. The Member/AR demonstrates an inability to manage Attendant support.

   c. The Member no longer meets program eligibility criteria due to deterioration in physical or cognitive health as determined by the Member's physician, physician assistant, or advance practice nurse.

   d. The Member/AR spends the monthly Allocation in a manner causing premature depletion of funds without authorization from the Case Manager or reserved funds. The Case Manager will follow the service utilization protocol.

   e. The Member/AR exhibits Inappropriate Behavior as defined at Section 8.7515.B toward Attendants, Case Managers, the Training and Support Contractor, or the Financial Management Services (FMS) Contractor.

   f. The Member/AR authorizes the Attendant to perform services while the Member is in a nursing facility, hospital, a long-term care facility or while incarcerated.

8.7515.O CDASS Immediate Involuntary Termination

1. Members may be involuntarily terminated immediately from CDASS for the following reasons:

a. A Member no longer meets program criteria due to deterioration in physical or cognitive health AND the Member refuses to designate an Authorized Representative (AR) to direct services.

b. The Member/AR demonstrates a consistent pattern of overspending their monthly Allocation leading to the premature depletion of funds AND the Case Manager has determined that attempts using the service utilization protocol to assist the Member/AR to resolve the overspending have failed.

c. The Member/AR exhibits Inappropriate Behavior as defined at Section 8.7515.B toward Attendants, Case Managers, the Training and Support Contractor or the Financial Management Services (FMS) Contractor, and the Department has determined that the Training and Support Contractor has made attempts to assist the Member/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

d. Member/AR authorized the Attendant to perform services for a person other than the Member, authorized services not available in CDASS, or allowed services to be performed while the Member is in a hospital, nursing facility, a long-term care facility or while incarcerated and the Department has determined the Training and Support Contractor has made adequate attempts to assist the Member/AR in managing appropriate services through ~~retraining~~mandatory coaching.

e. Intentional submission of fraudulent CDASS documents or information to Case Managers, the Training and Support Contractor, the Department, or the FMS Contractor.

f. Instances of proven fraud, abuse, and/or theft in connection with the Colorado Medical Assistance program.

g. Member/AR fails to complete ~~retraining~~mandatory coaching, appoint an AR, or remediate CDASS management per Section 8.7515.N.1.

h. Member/AR demonstrates a consistent pattern of non-compliance with Electronic Visit Verification (EVV) requirements determined by the EVV CDASS protocol.

i. Members experiencing FMS EVV systems issues must notify the FMS Contractor and/or Department of the issue within five (5) business days. In the event of a confirmed FMS EVV system outage or failure impacting EVV submissions, the Department will not impose strikes or pursue termination, as appropriate, as outlined in the EVV Compliance protocol.

8.7515.P Ending t~~T~~he CDASS Delivery Option

1. If a Member chooses to use an alternate care option or is terminated involuntarily, the Member will be terminated from CDASS when the Case Manager has secured an adequate alternative to CDASS in the community.

2. In the event of discontinuation of or termination from CDASS, the Case Manager shall:

a. Complete the Long Term Care Notice of Action (LTC-803) and provide the Member or Authorized Representative (AR) with the reasons for termination, information about the Member's rights to fair hearing, and appeal procedures. Once notice has been given for

termination, the Member or AR may contact the Case Manager for assistance in obtaining other home care services or additional benefits, if needed.

b. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS and begin alternate care services. Exceptions may be made to increase or decrease the thirty (30) day advance notice requirement when the Department has documented that there is danger to the Member. The Case Manager shall notify the FMS Contractor of the date on which the Member is being terminated from CDASS.

3. Members who are involuntarily terminated pursuant to Sections 8.7515.O.1.b, 8.7515.O.1.d, 8.7515.O.1.e, 8.7515.O.1.f, and 8.7515.O.1.g may not be re-enrolled in CDASS as a service delivery option.

4. Members who are involuntary terminated pursuant to Section 8.7515.O.1.a are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at 8.7515.C.1.e. The Member or AR must have successfully completed CDASS ~~training~~ orientation prior to enrollment in CDASS.

5. Members who are involuntary terminated pursuant to 8.7515.O.1.c are eligible for enrollment in CDASS with the appointment of an AR. The Member must meet all CDASS eligibility requirements with the AR completing CDASS ~~training~~ orientation prior to enrollment in CDASS.

6. Members who are involuntarily terminated pursuant to 8.7515.O.1.h are eligible for enrollment in CDASS 365 days from the date of termination. The Member must meet all eligibility requirements and complete CDASS ~~training~~ orientation prior to enrollment in CDASS.

8.7515.Q CDASS Case Management Functions

1. The Case Manager shall review and approve the Attendant Support Management Plan (ASMP) completed by the Member/Authorized Representative (AR). The Case Manager shall notify the Member/AR of ASMP approval and establish a service period and Allocation.

2. If the Case Manager determines that the ASMP is inadequate to meet the Member's CDASS needs, the Case Manager shall work with the Member/AR to complete a fully developed ASMP.

3. The Case Manager shall calculate the Allocation for each Member who chooses CDASS as follows:

a. Calculate the number of personal care, homemaker, and health maintenance activities hours needed on a monthly basis using the Department's prescribed method. The needs determined for the Allocation should reflect the needs in the Department-approved Assessment tool and the service plan. The Case Manager shall use the Department's established rate for personal care, homemaker, and health maintenance activities to determine the Member's Allocation.

b. The Allocation should be determined using the Department's prescribed method at the Member's initial CDASS enrollment and at Reassessment. Service authorization will align with the Member's need for services and adhere to all service authorization requirements and limitations established by the Member's waiver program.

c. The Case Manager shall follow the Department's assessment~~utilization management review~~ process and receive prior authorization before authorizing a CDASS start date for Attendant services for Person-Centered Support Plan that;

i. Contain Health Maintenance Activities; or

ii. ~~Service Accommodation requests~~Exceed the cost of care received in an institutional setting.

4. Prior to ~~training~~ orientation or when an Allocation changes, the Case Manager shall provide written Notification of the Allocation to the Member and the AR, if applicable.

5. A Member or AR who believes the Member needs a change in Attendant support, may request the Case Manager to perform a review of the Direct Care Services Calculator ~~CDASS Task Worksheet~~ and CDASS Allocation for services. Review should be completed within five (5) business days.

a. If the review indicates that a change in Attendant support is justified, the following actions will be taken:

i. The Case Manager shall provide notice of the Allocation change to the Member/AR utilizing a long-term care notice of action form within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

ii. The Case Manager shall complete a Prior Authorization Request (PAR) revision indicating the increase in CDASS Allocation using the Department's Medicaid Management Information System and FMS Contractor system. Prior Authorization Request (PAR) revisions shall be completed within five (5) business days of the Allocation determination.

iii. The Member/AR shall amend the ASMP and submit it to the Case Manager.

b. The Training and Support Contractor is available to facilitate a review of services and provide mediation when there is a disagreement in the services authorized on the Direct Care Services Calculator~~CDASS Task Worksheet~~.

c. The Case Manager will notify the Member of CDASS Allocation approval or disapproval by providing a long-term care notice of action form to Members within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

6. In approving an increase in the Member's Allocation, the Case Manager shall consider the following:

a. Any deterioration in the Member's functioning or change in availability of natural supports, meaning assistance provided to the Member without the requirement or expectation of compensation;

b. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services; and

c. The appropriate use and application of funds for CDASS services.

7. In reducing a Member's Allocation, the Case Manager shall consider:

   a. Improvement of functional condition or changes in the available natural supports;

   b. Inaccuracies or misrepresentation in the Member's previously reported condition or need for service; and

   c. The appropriate use and application of funds for CDASS services.

8. Case Managers shall cease payments for all existing Medicaid-funded personal care, homemaker, and/or health maintenance activities ~~and/or Long-Term Home Health as defined under the Home Health Program at Section §8.520 et seq.~~ as of the Member's CDASS start date.

9. For effective coordination, monitoring and evaluation of Members receiving CDASS, the Case Manager shall:

   a. Contact the CDASS Member/AR once a month during the first three months to assess their CDASS management, their satisfaction with Attendants, and the quality of services received. Case Managers may refer Members/ARs to the FMS Contractor for assistance with payroll and to the Training and Support Contractor for training needs, budgeting, and support.

   b. Contact the Member/AR quarterly after the first three months to assess their implementation of Attendant services, CDASS management issues, quality of care, Allocation expenditures, and general satisfaction.

   c. Contact the Member/AR when a change in AR occurs and contact the Member/AR once a month for three months after the change takes place.

   d. Review monthly FMS Contractor reports to monitor Allocation spending patterns and service utilization to ensure appropriate budgeting and follow up with the Member/AR when discrepancies occur.

   e. Utilize Department overspending protocol when needed to assist CDASS Member/AR.

   f. Follow protocols established by the Department for Case Management Activities.

10. Reassessment: The Case Manager will follow in-person and phone contact requirements based on the Member's waiver program or CFC requirements. Contacts shall include a review of care needs, the ASMP, and documentation from the physician, physician assistant, or advance practice nurse stating the Member's ability to direct care.

11. Case Managers shall participate in training and consulting opportunities with the Department's contracted Training and Support Contractor.

8.7515.R CDASS Attendant Reimbursement

1. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the Member/Authorized Representative (AR) hiring the Attendant. Wages shall be established in accordance with Colorado Department of Labor and Employment standards including, but not limited to, minimum wage and overtime requirements. Attendant wages may not be below the local, state, and federal requirements for the location where the service is provided. The Financial Management Services (FMS) Contractor shall make

all payments from the Member's Allocation under the direction of the Member/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified in the Attendant Support Management Plan (ASMP).

2. Attendant timesheets that exceed the Member's monthly CDASS Allocation by 30% or more are not allowed and cannot be authorized by the Member or AR for reimbursement through the FMS Contractor unless prior approval is obtained from the Department or its designee.

3. Once the Member's yearly Allocation is used, further payment will not be made by the FMS Contractor, even if timesheets are submitted. Reimbursement to Attendants for services provided when a Member is no longer eligible for CDASS or when the Member's Allocation has been depleted are the responsibility of the Member/AR.

~~4. Allocations that exceed the cost of providing services in a facility cannot be authorized by the Case Manager without Department approval.~~

8.7515.S CDASS Reimbursement to Family Members

1. Family Members/legal Guardians may be employed by the Member/Authorized Representative (AR) to provide CDASS, subject to the conditions below.

a. The Family Member or legal Guardian shall be employed by the Member/AR and be supervised by the Member/AR.

b. The Family Member and/or legal Guardian being reimbursed as a personal care, homemaker, and/or health maintenance activities Attendant shall be reimbursed at an hourly rate with the following restrictions:

~~i. A Family Member and/or legal Guardian shall not be reimbursed for more than forty (40) hours of CDASS in a seven-day period from 12:00 am on Sunday to 11:59 pm on Saturday.~~

i~~i~~. Family Member wages shall be commensurate with the level of skill required for the task and should not deviate from that of a non-Family Member Attendant unless there is evidence that the Family Member has a higher level of skill.

ii~~i~~. A Member of the Member's household may only be paid to furnish extraordinary care as determined by the Case Manager. Extraordinary care is determined by assessing whether the care to be provided exceeds the range of care that a Family Member would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the Member and/or avoid institutionalization. Extraordinary care shall be documented on the service plan.

c. Legally Responsible Persons shall not be reimbursed for more than 520 hours of homemaker services annually.

d. A Member/AR who chooses a Family Member as a care provider, shall document the choice on the Attendant Support Management Plan (ASMP).

8.7520 Electronic Monitoring

8.7520.A Electronic Monitoring Eligibility

1. Electronic Monitoring is a covered benefit available to Members enrolled in CFC. ~~one of the following HCBS waivers:~~

~~a. Brain Injury Waiver~~

~~b. Community Mental Health Supports Waiver~~

~~c. Complementary and Integrative Health Waiver~~

~~d. Elderly, Blind, and Disabled Waiver~~

~~e. Supported Living Services Waiver~~

8.7520.B Electronic Monitoring Definitions

1. Electronic Monitoring services means electronic equipment, or adaptations, that are related to an eligible person's disability and/or that enable the Member to remain at home, and includes the installation, purchase, or rental of electronic monitoring devices which:

    a. Enable the Member to secure help in the event of an emergency;

    b. May be used to provide reminders to the Member of medical appointments, treatments, or medication schedules;

    c. Are required because of the Member's illness, impairment or disability as identified and documented in the Person-Centered Support Plan or service plan; and

    d. Are essential to prevent institutionalization of the Member.

2. Electronic Monitoring Provider means a Provider Agency as defined in Section 8.7400 and Section 25.5-6-303. C.R.S., that has met the Provider Agency requirements for electronic monitoring services specified in Section 8.7520.E.

3. Medication Reminders means devices, controls, or appliances that remind or signal the participant to take actions related to medications

4. Personal Emergency Response System (PERS) means ongoing remote monitoring through a device designed to signal trained alarm monitoring personnel in an emergency situation.

8.7520.C Electronic Monitoring Inclusions

1. Electronic monitoring services shall include personal emergency response systems, medication reminder systems, or other devices which comply with the definition above and are not included in the non-benefit items below at Section 8.7520.D.

8.7520.D Electronic Monitoring Exclusions and Limitations

1. Electronic Monitoring services shall be authorized ~~only~~ for Members who live alone or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision.

2. Electronic Monitoring services shall be authorized ~~only~~ for Members who have the physical and mental capacity to utilize the particular system requested for that Member.

3. Electronic Monitoring services shall not be authorized as a~~n HCBS~~ CFC benefit if the service or device is available elsewhere as a state plan Medicaid benefit.

4. The following are not benefits of electronic monitoring services:

   a. Augmentative communication devices and communication boards;

   b. Hearing aids and accessories;

   c. Phonic ears;

   d. Environmental control units, unless required for the medical safety of a Member living alone unattended; or as part of Remote Supports;

   e. Computers and computer software unrelated to the provision of Remote Supports;

   f. Wheelchair lifts for automobiles or vans

   g. Exercise equipment, such as exercise cycles; or

   h. Hot tubs, Jacuzzis, or similar items.

8.7520.E Electronic Monitoring Provider Agency Requirements

1. Electronic Monitoring Provider Agencies shall conform to the following standards for electronic monitoring services:

   a. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be Federal Communications Commission (FCC) registered.

   b. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer and/or Provider Agency of Electronic Monitoring shall train the Member in the use of the device as requested by the Member.

   c. All equipment, materials or appliances shall be tested for proper functioning at the time of installation, and at periodic intervals thereafter, and be maintained based on the manufacturer’s recommendations. Any malfunction shall be promptly repaired, and equipment shall be replaced when necessary, including buttons and batteries.

   d. All telephone calls generated by monitoring equipment shall be toll-free, and all Members shall be allowed to run unrestricted tests on their equipment.

   e. Electronic Monitoring Provider Agencies shall send written information to each Member's Case Manager about the system, how it works, and how it will be maintained.

8.7520.F Electronic Monitoring Reimbursement

1. Payment for Electronic Monitoring services shall be the lower of the billed charges or the prior authorized amount.

2. For Electronic Monitoring the unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly.

3. No reimbursement is available for Electronic Monitoring in Provider-owned, -Controlled, or Congregate Facilities.

8.7522 Extraordinary Cleaning

8.7522.A Extraordinary Cleaning Eligibility

1. Extraordinary Cleaning Services is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Children's Extensive Support Waiver

    b. Supported Living Services Waiver

8.7522.B Extraordinary Cleaning Definitions

1. Extraordinary Cleaning means specialized cleaning, disinfection, and sanitization services necessary to ensure a safe, hygienic living environment and prevent the spread of infectious diseases~~disease~~ or pathogens. Extraordinary cleaning includes the use of commercial-grade products, infection control protocols, handling and disposal of biohazard materials, and specialized materials or equipment.

2. Personal Protective Equipment (PPE) is equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. Personal protective equipment may include items such as gloves, safety glasses and shoes, well-fitting masks or NIOSH-approved respirators, gowns, shoe covers, etc.

3. Commercial-Grade Product means a cleaning substance or mixture of substances registered with the Environmental Protection Agency (EPA) that destroys or irreversibly inactivates bacteria, fungi, and viruses. The product must be clearly labeled and registered with the EPA and must be stored in a location sufficiently secure to deny access to children, pets, or at-risk adults.

4. Standard Precautions means an infection-control principle that treats all blood, bodily fluids and other potentially infectious materials as infectious.

8.7522.C Extraordinary Cleaning Inclusions

1. Service shall be for the benefit of the Member and not for the benefit of other persons living in the home. Extraordinary Cleaning services must be completed within spaces a Member frequents such as their home or vehicle.

2. Extraordinary Cleaning tasks are beyond routine homemaking tasks and are necessary to ensure a safe and hygienic living environment due to or as a result of a Member's disability.

3. Services include professional and specialized cleaning, disinfection, and/or sanitization. Tasks require specialized knowledge, training, and use of Commercial-Grade Products and equipment. Providers must use standard precautions and personal protective equipment in the provision of services, when applicable.

4. Extraordinary Cleaning services may be authorized due to a member's disabilities/behaviors causing an unsafe and unsanitary living environment for the Member which requires extraordinary cleaning to mitigate. The Member's needs must be documented in the Person-Centered Support plan and then outlined in the Provider Care Plan or included in sub-contractor documentation, along with details on how the service frequency and scope is appropriate to address concerns.

5. Extraordinary Cleaning tasks may include:

a. Cleaning floors and other household surfaces including wood, laminate, engineered flooring materials, vinyl, tile, carpets or rugs, counters, and/or walls using Commercial-Grade Products and equipment.

i. Cleaning, sanitization and disinfection of mattresses, surfaces, furniture, upholstery, and other household items requiring use of Commercial-Grade Products and equipment.

b. Laundering and disinfecting a member's clothing, towels, bedding or linens soiled with blood or other bodily fluids. Laundry services or commercial/professional laundering may be appropriate to manage the laundering needs.

c. Air duct cleaning that is essential for the health and safety of the member that mitigates disability-related health complications.

8.7522.D Extraordinary Cleaning Exclusions and Limitations

~~t~~1. Extraordinary Cleaning service may NOT include: ~~t~~

a. Personal care services.

b. Homemaker services.

c. Services the member can perform independently.

d. Adaptations or improvements to the home that are considered to be on-going home maintenance and are not of direct medical or remedial benefit to the Member.

e. Services that are not essential to the health and safety of the Member.

f. Services that do not meet the task definition for Extraordinary Cleaning may not be approved.

g. Services that are deemed typical parental responsibility may not be approved.

h. Services that do not follow Age- Appropriate Guidelines may not be approved.

i. Extraordinary cleaning services provided in Uncertified Congregate Facilities may not be approved.

j. In the case a Member resides in a rental property, the responsibility of the landlord, pursuant to the lease agreement, must be examined prior to the authorization of service.

8.7522.E Extraordinary Cleaning Case Management Agency Responsibilities:

1. Detailed, task-related goals shall be documented by the case manager in the Person-Centered Support Plan, including documentation and goals of extraordinary cleaning projects as it relates to improving the health and safety of the Member.

2. Requests for costs that exceed an amount equal to 700 15-minute units over the course of a Support Plan year may be approved by the Department, as prescribed by the Department, if it:

   a. Ensures the health and safety of the Member in the home;

   b. Decreases the need for paid assistance in another HCBS waiver service or CFC on a long-term basis.

3. Case Management Agency approval for a higher amount shall include a thorough review of the current request to ensure cost effectiveness and no unnecessary duplication.

8.7522.F Extraordinary Cleaning Provider Agency Requirements

1. A provider enrolled with Colorado Medicaid or contracting with a Case Management Agency to provide the Extraordinary Cleaning service must be a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and hold a Certificate of Good Standing to do business in Colorado.

8.7522.G Extraordinary Cleaning Provider Services Reimbursement Requirements

1. HCBS Supported Living Services (SLS) Waiver; Children's Extensive Support (CES) Waiver:

   a. Payment does not include travel time to or from the Member's residence. a. Payment does not include travel time to or from the Member's residence.

   b. Reimbursement shall not exceed an amount equal to 700 15-minute units and may be billed as a 15-minute unit and/or project total for services rendered.

   c. Work that was completed prior to authorization by the Department or Case Management Agency is not eligible for reimbursement.}

8.7523 Health Maintenance Activities Self-Directed

8.7523.A Health Maintenance Activities Eligibility

1. Health Maintenance is available to Members eligible for Consumer Directed Attendant Support Services (CDASS) or In-Home Support Services (IHSS) within CFC. ~~within the following HCBS waivers:~~

   ~~a. Brain Injury Waiver~~

   ~~b. Community Mental Health Supports Waiver~~

   ~~c. Complementary and Integrative Health Waiver~~

   ~~d. Elderly, Blind, and Disabled Waiver~~

   ~~e. Supported Living Services Waiver~~

~~2. Health Maintenance is available to Members eligible for In-Home Support Services within the following HCBS waivers:~~

~~a. Children's Home and Community-Based Services Waiver~~

~~b. Complementary and Integrative Health Waiver~~

~~c. Elderly, Blind, Disabled Waiver~~

8.7523.B Health Maintenance Activities Definition

1. Health Maintenance means routine and repetitive health related tasks furnished to an eligible Member in the community or in the Member's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out.

a. Health Maintenance Activities requires a skilled acuity assessment to be completed by the authorized Nurse Assessor Vendor, as defined in 8.520.1.V prior to the completion of a PAR.

2. Home Exercise Plan is an exercise plan that is developed by a L~~l~~icensed M~~m~~edical P~~p~~rofessional, an occupational therapist, a speech language pathologist, a Registered Nurse, or physical therapist that instructs the Member what exercises must be completed in the home or in the community. The exercises identified in the Home Exercise Plan must not replace the services that are traditionally received through Occupational Therapy, Physical Therapy, and/or Speech Therapy services.

8.7523.C Health Maintenance Activities Inclusions

1. Services may include:

a. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection and the Member is unable to apply creams, lotions, sprays, or medications independently due to illness, injury, or disability. Skin care may include wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when directed by a Licensed Medical Professional (LMP).

b. Hair care includes shampooing, conditioning, drying, and combing when performed in conjunction with health maintenance level bathing, dressing, or skin care. Hair care may be performed when:

i. The Member is unable to complete task independently;

ii. Application of a prescribed shampoo/conditioner which has been dispensed by a pharmacy; or

iii. The Member has open wound(s) or neck stoma(s).

c. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing, and trimming.

d. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:

i. There is injury or disease of the face, mouth, head, or neck;

ii. In the presence of communicable disease;

iii. When the Member is unable to participate in the task;

iv. Oral suctioning is required;

v. There is decreased oral sensitivity or hypersensitivity;

vi. The Member is at risk for choking and aspiration.

e. Shaving performed when health maintenance level skin care is required in conjunction with the shaving, or:

i. The Member has a medical condition involving peripheral circulatory problems;

ii. The Member has a medical condition involving loss of sensation;

iii. The Member has an illness or takes medications that are associated with a high risk for bleeding;

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

f. Dressing performed when health maintenance-level skin care or transfers are required in conjunction with the dressing, or:

i. Assistance with the application of prescribed anti-embolic or pressure stockings is required;

ii. Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.

g. Feeding is considered a health maintenance task when the Member requires health maintenance-level skin care or dressing in conjunction with the task, or:

i. Oral suctioning is needed on a stand-by or intermittent basis;

ii. The Member is on a prescribed modified texture diet;

iii. The Member has a physiological or neurogenic chewing or swallowing problem;

iv. Syringe feeding or feeding using adaptive utensils is required;

v. Oral feeding when the Member is unable to communicate verbally, non-verbally or through other means.

h. Exercise including passive range of motion. Exercises must be specific to the Member's documented medical condition and require hands-on assistance to complete. A Home Exercise Plan must be developed by a Licensed Medical Professional, Occupational Therapist, a speech language pathologist, a Registered Nurse, or Physical Therapist. ~~Exercise including passive range of motion. Exercises must be specific to the Member's documented medical condition and require hands-on assistance to complete.~~

i. Registered nurses who are affiliated with the Home Care Agency in which the member receives services are not permitted to develop the home exercise plan

for the member in which they are serving. ~~For CDASS, a home exercise plan must be prescribed by a Licensed Medical Professional, Occupational Therapist, or Physical Therapist.~~

i. Transferring a Member when they are not able to perform transfers independently due to illness, injury, or disability, or:

  i. The Member lacks the strength and stability to stand, maintain balance or bear weight reliably;

  ii. The Member has not been deemed independent with Adaptive Equipment or assistive devices by a Licensed Medical Professional;

  iii. The use of a mechanical lift is needed.

j. Bowel care performed when health maintenance-level skin care or transfers are required in conjunction with the bowel care, or:

  i. The Member is unable to assist or direct care;

  ii. Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;

  iii. Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.

k. Bladder care performed when health maintenance-level skin care or transfers are required in conjunction with bladder care, or;

  i. The Member is unable to assist or direct care;

  ii. Care of external, indwelling, and suprapubic catheters;

  iii. Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.

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

m. Respiratory care:

  i. Postural drainage;

  ii. Cupping;

  iii. Adjusting oxygen flow within established parameters;

  iv. Suctioning mouth and/or nose;

  v. Nebulizers;

  vi. Ventilator and tracheostomy care;

vii. Assistance with set-up and use of respiratory equipment.

n. Bathing assistance is considered a health maintenance task when the Member requires health maintenance-level skin care, transfers or dressing in conjunction with bathing.

o. Medication assistance, which may include setup, handling and administering medications.

i. For In-Home Support Services (IHSS) only, The IHSS Agencies Licensed Health Care Professional must validate Attendant skills for medication administration and ensure that the completion of task does not require clinical judgment or Assessment skills.

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

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

i. The Member is unable to assist or direct care;

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

iii. The Member has not been deemed independent with Adaptive Equipment or assistive devices ordered by a Licensed Medical Professional

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

i. The Member is unable to assist or direct care, or

ii. The Member is unable to complete task independently

2. Additional HMA inclusion criteria for children are available within the Health Maintenance Activities Documentation Guide.

8.7526 Home Delivered Meals

8.7526.A Home Delivered Meals Eligibility

1. Home Delivered Meals is a covered benefit available to Members enrolled in CFC. ~~one of the following HCBS waivers:~~

~~a. Brain Injury Waiver~~

~~b. Community Mental Health Supports Waiver~~

~~c. Complementary and Integrative Health Waiver~~

~~d. Elderly, Blind, and Disabled Waiver~~

~~e. Supported Living Services Waiver~~

~~f. Developmental Disability Waiver~~

8.7526.B Home Delivered Meals Definition

1. ~~Home Delivered Meals means nutritional counseling, planning, preparation, and delivery of meals to Members who have dietary restrictions or specific nutritional needs, are unable to prepare their own meals, and have limited or no outside assistance.~~ Home Delivered Meals means delivery of meals to Members who have dietary restrictions or specific nutritional needs, are unable to prepare their own meals, and have limited or no outside assistance. At the Member's request, this service may also include nutrtitional counseling and meal planning

8.7526.C Home Delivered Meals Inclusions

1. Home Delivered Meals may include:

~~a.~~ a. Meals intended to support member wellness, which may include meals tailored to the member's nutritional needs.

~~b.~~ b. Meal planning developed for the Member's individual needs which may include nutritional meal planning, nutritional counseling, selected meal types, and instructions for meal preparation and delivery.

2. To obtain approval for Home Delivered Meals, the Member must demonstrate a need for the service, as follows:

a. The member is transitioning from an institutional setting to a home and community-based setting; and/or

b. The member demonstrates the following:

i. The Member lacks or has limited access to outside assistance, services, or resources through which they can access meals; and

ii. The Member is unable to prepare meals to sustain health, or has dietary restrictions, or has specific nutritional needs; and

iii. The Member's inability to access and/or prepare nutritious meals demonstrates a risk to the member's health or safety, or institutionalization; decreasing independence and increasing the need for human intervention or assistance.

~~a. The Member demonstrates a need for nutritional counseling, meal planning, and preparation;~~

~~b. The Member shows documented dietary restrictions or specific nutritional needs;~~

~~c. The Member lacks or has limited access to outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their dietary restrictions or special nutritional needs;~~

~~d. The Member is unable to prepare meals with the type of nutrition vital to meeting their dietary restrictions or special nutritional needs;~~

~~e. The Member's inability to access and prepare nutritious meals demonstrates a need-related risk to health, safety, or institutionalization~~

~~2. To establish eligibility for Home Delivered Meals, for Members transitioning into the community, the Member must satisfy general criteria for accessing service:~~

~~a. The Member is transitioning from an institutional setting to a Home and Community-Based setting, or is experiencing a qualifying change in life circumstance that affects a Member's stability and endangers their ability to remain in the community;~~

~~b. The Member demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and~~

~~c. The Member demonstrates that they need the service to establish community supports or resources where they may not otherwise exist.~~

~~d. Members accessing Home Delivered Meals post-hospital discharge must have been discharged from the hospital following a 24-hour admission.~~

8.7526.D Home Delivered Meals Service Requirements

1. The Member's Provider Care Plan must specifically identify:

   a. ~~The Member's need for individualized nutritional counseling and development of a Nutritional Meal Plan~~ Any individualized nutritional counseling or nutritional meal plan requested by the Member, which describes the Member's nutritional needs and selected meal types, and provides instructions for meal preparation and delivery; and

   b. The Member's specifications for preparation and delivery of meals, and any other detail necessary to effectively implement the individualized meal plan.

2. The service must be provided in the home or community and in accordance with the Member's Person-Centered Support Plan. All Home Delivered Meal services shall be documented in the Provider Care Plan.

3. ~~For Members transitioning into the community, the~~ The assessed need is documented in the Member's service plan as part of their skills acquisition process of gradually becoming capable of preparing their own meals or establishing the resources to obtain their needed meals.

4. Members ~~transitioning into the community~~ may be approved for Home Delivered Meals for no more than 365 days. ~~The Department, in its sole discretion, may grant an exception based on extraordinary circumstances.~~Home Delivered Meals may be authorized past 365 days on a case-by-case basis if there is a demonstrated need.

~~5. Members accessing meals post-hospital discharge may be approved for Home Delivered Meals for no more than 30 days post qualifying hospital discharge. Benefit may be accessed for no more than two 30-day periods during a Member's certification period.~~

5~~6~~. Meals are to be delivered up to two meals per day, with a maximum of 14 meals delivered per week.

6~~7~~. Meals may include liquid, mechanical soft, or other medically necessary types.

7~~8~~. Meals may include ethnic or cultural options.~~be ethnically or culturally tailored.~~

8~~9~~. Meals may be delivered hot, cold, frozen, or shelf-stable, depending on the Member's or caregiver's ability to complete the preparation of, and properly store the meal.

9~~10~~. The Provider Agency shall confirm meal delivery, by attestation of the deliverer or carrier proof of delivery, to ensure the Member receives the meal in a timely fashion, and to determine whether the Member is satisfied with the quality of the meal.

10~~11~~. ~~For Members transitioning into the community, t~~The ~~providing Agency's certified RD or RDN~~The Home Delivered Meals provider will check in with the Member no less frequently than every 90 days to ensure the meals are satisfactory, that they promote the Member's health, and that the service is meeting the Member's needs.

11~~12~~. ~~For Members transitioning into the community, the~~ The ~~RD or RDN~~case manager will review a Member's progress toward the nutritional goal(s) described in the Member's Provider Care Plan no less frequently than once per calendar quarter, and more frequently, as needed. If the case manager has concerns regarding the Member's progress toward the nutritional goal(s), they should refer back to the Home Delivered Meals provider to schedule a nutritional counseling session with a RD or RDN.

12~~13~~. ~~For Members transitioning into the community, the~~ The RD or RDN shall make changes to the Nutritional Meal Plan if the quarterly assessment results show changes are necessary or appropriate.

a. ~~For Members transitioning into the community, t~~The ~~RD or RDN~~Home Delivered Meals provider will send the Nutritional Meal Plan to the Case Management Agency no less frequently than once per quarter to allow the Case Management Agency to verify the plan with the Member during the quarterly check-in~~,~~. The case manager will ~~and to~~ make corresponding updates to the Person-Centered Support Plan, as needed.

8.7526.E Home Delivered Meals Exclusions and Limitations

1. Home Delivered Meals are not available when the Member resides in a provider-owned or controlled setting.

2. Delivery must not constitute a full nutritional regimen and includes no more than two meals per day or 14 meals per week.

3. Items or services through which the Member's need for Home Delivered Meal services may otherwise be met, including any item or service available under the State Plan, applicable HCBS waiver, or other resources are excluded.

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

5. Meal plans and meals provided are reimbursable when they benefit the Member, only. Services provided to someone other than the Member are not reimbursable.

8.7526.F Home Delivered Meals Provider Agency Requirements

1. A licensed provider enrolled with Colorado Medicaid to provide the Home Delivered Meal service must be a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and holding a Certificate of Good Standing to do business in Colorado.

2. Home Delivered Meal Provider Agencies must conform to all general Certification standards, conditions, and processes established in Section 8.7400.

3. The Provider Agency shall maintain licensure as required by the State of Colorado Department of Public Health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for staff; or be approved by Medicaid as a home delivered meals provider in their home state.

4. The Provider Agency must maintain a Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN) on staff or under contract.

5. The Provider Agency shall maintain meals documentation in accordance with Section 8.7405 and shall provide documentation to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request. Required documentation includes:

    a. Documentation pertaining to the Provider Agency, including employee files, claim submission documents, program and financial records, insurance policies, and licenses, including a Retail Food License and Food Handling License for Staff, or, if otherwise applicable, documentation of compliance and good standing with the City and County municipality in which this service is provided; and

    b. Documentation pertaining to services, including:

        i. Documentation of any professionally recommended dietary restrictions or specific nutritional needs;

        ii. Member demographic information;

        iii. A Meal Delivery Schedule;

        iv. Documentation of special diet requirements;

        v. A determination of the type of meal to be provided (e.g. hot, cold, frozen, shelf stable);

        vi. A record of the date(s) and place(s) of service delivery (e.g. through documented driver attenstation or proof of carrier delivery);

        vii. Monitoring and follow-up (contacting the Member after meal deliver to ensure the Member is satisfied with the meal); and

        viii. Provision of nutrition counseling or documentation of Member declination.

8.7526.G Home Delivered Meals Provider Agency Reimbursement

1. Home Delivered Meals services are reimbursed based on the number of units of service provided, with one unit equal to one meal.

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

3. Reimbursement is limited to services described in the Provider Care Plan.

8.7527 Homemaker Services

8.7527.A Homemaker Services Eligibility

1. Homemaker Services is a covered benefit available to Members enrolled in CFC. ~~one of the following HCBS waivers:~~

~~a. Brain Injury Waiver when the Member is receiving Personal Care as defined at 8.7537~~

~~b. Children's Extensive Support Waiver~~

~~c. Community Mental Health Supports Waiver~~

~~d. Complementary and Integrative Health Waiver~~

~~e. Elderly, Blind, and Disabled Waiver~~

~~f. Supported Living Services Waiver~~

8.7527.B Homemaker Services Definitions

1. Homemaker Provider Agency means a Provider Agency that is certified by the state fiscal agent to provide Homemaker Services.

2. Homemaker means services provided to an eligible Member that include general household activities to maintain a healthy and safe home environment for a Member.

8.7527.C Homemaker Services Inclusions

1. ~~HCBS Elderly, Blind, and Disabled (EBD Waiver; Brain Injury (BI) Waiver when the Member is receiving Personal Care Service; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver:a.~~ Service shall be for the benefit of the Member and not for the benefit of other persons living in the home. Homemaker services, except for laundry, ~~and~~ shopping, and Acquisition, Maintenance, and Enhancement of Skills (AME) must be completed within the permanent living space.

2. ~~b.~~ Homemaker tasks may include:

   a.~~i.~~ Routine light house cleaning, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas.

   b.~~ii.~~ Meal preparation and menu planning.

   c.~~iii.~~ Dishwashing.

   d.~~iv.~~ Bedmaking.

   e.~~v.~~ Laundry.

   f.~~vi.~~ Shopping.

g.~~vii.~~ Banking/Money Management.~~Teaching the skills listed above to Members who are capable of learning to do such tasks for themselves. Teaching shall result in a required reevaluation of the teaching task every ninety days. If the Member has increased independence, the weekly units should decrease accordingly.~~

i. For CDASS: caregivers cannot be reimbursed to provide money management tasks that would typically be completed by an authorized representative as defined in 8.7515.H.

h. Appointment Management.

i. Homemaker Services includes the option for the Acquisition, Maintenance, and Enhancement of Skills (AME) task when the support is related to functional skills training and is desired by the member to accomplish Homemaker tasks to increase their independence and reduce supports needed in the home and community.

i. Detailed, task-related goals shall be documented by case manager in the Person-Centered Support Plan, including documentation monitoring progress and any decrease in human assistance previously authorized.

ii. AME services shall include direct training and instruction to the Member in performing homemaker tasks.

iii. The provider or attendant shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task.

~~2. HCBS Children's Extensive Support (CES) Waiver; Supported Living Services (SLS) Waiver:~~

~~a. Homemaker services are provided in the Member's home and are allowed when the Member's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency.~~

~~b. There are two types of homemaker services: Basic and Enhanced~~

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

~~1) Assistance may take the form of hands-on assistance including actually performing a task for the Member or cueing to prompt the Member to perform a task such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas.~~

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

~~1) Habilitation services shall include direct training and instruction to the Member 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 Member or enhanced prompting and cueing.~~

~~2) The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task:~~

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

~~b) To increase the independence of the Member,~~

~~3) 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 Member.~~

~~4) Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the Member's disability.~~

8.7527.D Homemaker Services Exclusions and Limitations

1. ~~HCBS Elderly, Blind, and Disabled (EBD Waiver; Brain Injury (BI) Waiver when the Member is receiving Personal Care Service; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Children's Extensive Support (CES) Waiver; Supported Living Services (SLS) Waiver~~ The CFC Homemaker service may NOT include:

   a. Personal care services.

   b. Services the person can perform independently.~~c. Homemaker services provided by Family Members:~~

   ~~i. In no case shall any person be reimbursed to provide services to his or her spouse.~~

   ~~ii. CES only: This service is limited to 2080 units per support plan year when provided by a legally responsible person(s).~~

   ~~iii. CDASS only: a Family Member or Member of the Member's household may only be paid to furnish extraordinary care as defined in 8.7515.02.~~

   c~~d~~. Homemaker services provided in Uncertified Congregate Facilities are not a benefit.

   d~~e~~. Lawn care, snow removal, routine air duct cleaning, and animal care are specifically excluded and shall not be reimbursed.

   e~~f~~. Billing for travel time is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.

   f~~g~~. Services that do not meet the task definition for Homemaker may not be approved.

2. When Homemaker services are provided by a legally responsible person:

   a. A legally responsible person or Member of the Member's household may only be paid to furnish extraordinary care as defined in 8.7514.B.11.~~02~~.

b. Legally Responsible Persons shall not be reimbursed for more than 520 hours of homemaker services annually.

8.7527.E Homemaker Services Provider Agency Requirements

1. ~~HCBS Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Brain Injury (BI) Waiver when the Member is receiving Personal Care Service; Community Mental Health Supports (CMHS) Waiver; Supported Living Services (SLS) Waiver:a.~~ All providers shall be certified by the Department as a Homemaker Provider Agency.

2. ~~b.~~ The Homemaker Provider Agency shall assure and document that all staff receive at least eight hours of training or have passed a skills validation test prior to providing unsupervised homemaker services. Training or skills validation shall include:

a.~~i.~~ Tasks included in Section 8.7527.C Homemaker Inclusions.

b.~~ii.~~ Proper food handling and storage techniques.

c.~~iii.~~ Basic infection control techniques including Universal Precautions.

d.~~iv.~~ Informing staff of policies concerning emergency procedures.

3. ~~c.~~ All Homemaker Provider Agency staff shall be supervised by a person who, at a minimum, has received training or passed the skills validation test required of homemakers, as specified above. Supervision shall include, but not be limited to, the following activities:

a.~~i.~~ Train staff on Agency policies and procedures.

b.~~ii.~~ Arrange and document training.

c.~~iii.~~ Oversee scheduling and notify Members of schedule changes.

d.~~iv.~~ Conduct supervisory visits to Member's homes at least every three months or more often as necessary for problem resolution, staff skills validation, observation of the home's condition and Assessment of Member's satisfaction with services.

i. ~~1)~~ Supervision should be flexible to the needs of the member and may be conducted via phone, video conference, telecommunication, or in-person.

1) ~~a)~~ If there is a safety concern with the services, the Provider Agency must make every effort to conduct an in-person Assessment.

2) ~~b)~~ The Provider Agency must conduct Direct Care Worker (DCW) supervision to ensure that Member care and treatment are delivered in accordance with a plan of care that addresses the Member status and needs.

8.7527.F Homemaker Provider Services Reimbursement Requirements:

1. ~~HCBS Elderly, Blind, and Disabled (EBD) Waiver; Brain Injury (BI) Waiver when the Member is receiving Personal Care Service; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Supported Living Services (SLS) Waiver:~~

~~a.~~ Payment for Homemaker Services shall be the lower of the billed charges or the maximum rate of reimbursement set by the Department. Reimbursement shall be per unit of 15 minutes.

2.~~b.~~ Payment does not include travel time to or from the Member's residence.

3.~~c.~~ If a visit by a home health aide from a home health Agency includes Homemaker Services, only the home health aide visit shall be billed.

4.~~d.~~ If a visit by a personal care provider from a personal care Provider Agency includes Homemaker Services, the Homemaker Services shall be billed separately from the personal care services.

5. Legally Responsible Persons shall not be reimbursed for more than 520 hours of homemaker services annually.

8.7528 In-Home Support Services (IHSS)

8.7528.A In-Home Support Services Eligibility

1. In-Home Support Services (IHSS) is a covered benefit available to Members enrolled in CFC. ~~in one of the following HCBS waivers:~~

~~a. Children's Home and Community-Based Services Waiver~~

~~b. Complementary and Integrative Health Waiver~~

~~c. Elderly, Blind, Disabled Waiver~~

8.7528.B In-Home Support Services Definitions

1. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS. A Family Member, including a spouse, may be an Attendant.

2. Authorized Representative means an individual designated by the Member, or by the Parent or Guardian of the Member, if appropriate, who has the judgment and ability to assist the Member in acquiring and receiving services under Title 25.5, Article 6, Part 12, C.R.S. The Authorized Representative shall not be the eligible person's service provider.

3. Care Plan means a written plan of care developed between the Member or the Member's Authorized Representative, In-Home Support Services (IHSS) Agency and Case Management Agency that is authorized by the Case Manager.

4. Extraordinary Care means a service that exceeds the range of care a ~~Family Member~~legally responsible person would ordinarily perform in a household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the Member and avoid institutionalization.

5. Inappropriate Behavior means documented verbal, sexual, or physical threats or abuse committed by the Member or Authorized Representative toward Attendants, Case Managers, or the In-Home Support Services (IHSS) Agency.

6. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of Institutions. These services include but are not limited to information and Referral services, independent living skills

training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and Institutions to Home and Community-Based living, or upon leaving secondary education.

7. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the Member or Member's Authorized Representative, including Health Maintenance Activities and support for Activities of Daily Living or Instrumental Activities of Daily Living, Personal Care services and Homemaker services.

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

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

8.7528.C In-Home Support Services Member Eligibility

1. To be eligible for In-Home Support Services (IHSS) the Member shall meet the following eligibility criteria:

   a. Be enrolled in CFC ~~a Medicaid program approved to offer IHSS~~.

   b. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition stating that the Member has sound judgment and the ability to self-direct care. If the Member is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.

   c. Members who elect or are required to have an Authorized Representative must appoint an Authorized Representative who has the judgment and ability to assist the Member in acquiring and using services.

   d. Demonstrate a current need for covered Attendant support services.

2. In-Home Support Services (IHSS) eligibility for a Member will end if:

   a. The Member is no longer enrolled in ~~a Medicaid program approved to offer IHSS.~~CFC

   b. The Member's medical condition deteriorates causing an unsafe situation for the Member or the Attendant as determined by the Member's Licensed Medical Professional.

   c. The Member refuses to designate an Authorized Representative when the Member is unable to direct their own care as documented by the Member's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.

   d. The Member provides false information or false records.

   e. The Member no longer demonstrates a current need for Attendant support services.

8.7528.D In-Home Support Services (IHSS) Inclusions and Covered Services

1. Services are for the benefit of the Member. Services for the benefit of other persons are not reimbursable.

~~2. Services available for eligible adults (as defined in EBD and CIH waivers):~~

~~a. Homemaker~~

~~b. Personal Care~~

~~c. Health Maintenance Activities~~

~~3. Services available for eligible children (as defined in the CHCBS waiver):~~

~~a. Health Maintenance Activities~~

2~~4~~. Service Inclusions:

a. Homemaker inclusions are set forth at Section 8.7527.C.

b. Personal Care inclusions are set forth at Section 8.7538.C.

c. Health Maintenance Activities inclusions are set forth at Section 8.7523.C.

8.7528.E In-Home Support Services (IHSS) Exclusions and Limitations

1. In-Home Support Services (IHSS) is a covered benefit for CFC members: ~~the HCBS Elderly, Blind, and Disabled (EBD), Complementary Integrative Health (CIH), and Children's Home and Community-Based Services (CHCBS) Waivers:~~

a. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and Prior Authorization Request (PAR) must be submitted and approved by the Case Manager and received by the IHSS Agency prior to services being rendered. Services rendered in advance of approval and receipt of these documents are not reimbursable.

b. Services rendered by an Attendant who shares living space with the Member or Family Members are reimbursable only when the Case Manager determines, prior to the services being rendered, that the services meet the definition of Extraordinary Care.

c. Health Maintenance Activities may include related Personal Care and/or Homemaker services if such tasks are completed in conjunction with the Health Maintenance Activity and are secondary or contiguous to the Health Maintenance Activity.

i. Secondary means in support of the main task(s). Secondary tasks must be routine and regularly performed in conjunction with a Health Maintenance Activity. The Case Manager must document evidence that the secondary task is necessary for the health and safety of the Member. Secondary tasks do not add units to the care plan.

ii. Contiguous means before, during or after the main task(s). Contiguous tasks must be completed before, during, or after the Health Maintenance Activity. The Case Manager must document evidence that the contiguous task is necessary for the health and safety of the Member. Contiguous tasks do not add units to the care plan.

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

d. Independent Living Core Services, Attendant training, and oversight or supervision provided by the IHSS Agencies Licensed Health Care Professional are not separately reimbursable. No additional compensation is allowable to IHSS Agencies for providing these services.

e. Billing for travel time is prohibited. Accompaniment of a Member by an Attendant in the community is reimbursable. IHSS Agencies must follow all Department of Labor and Employment guidelines on time worked.

f. Companionship is not a benefit of IHSS and shall not be reimbursed.~~2. HCBS Children's Home and Community-Based (CHCBS) Waiver:~~

~~a. In-Home Support Services (IHSS) for CHCBS shall be limited to tasks defined as Health Maintenance Activities.~~

~~b. Family Members of a Member can only be reimbursed for extraordinary care.~~

~~3. HCBS Elderly, Blind, and Disabled (EBD), Complementary Integrative Health (CIH) Waivers:~~

~~a. Family Members shall not be reimbursed for more than forty (40) hours of Personal Care services in a seven (7) day period.~~

~~b. Restrictions on allowable Personal Care units shall not apply to Parents who provide Attendant services to their eligible adult children through In-Home Support Services.~~

8.7528.F In-Home Support Services (IHSS) Member and Authorized Representative Participation and Self-Direction

1. A Member or their Authorized Representative may self-direct the following aspects of service delivery:

a. Present a person(s) of their own choosing to the In-Home Support Services (IHSS) Agency as a potential Attendant. The Member must have adequate Attendants to assure compliance with all tasks in the Care Plan.

b. Train Attendant(s) to meet their needs.

c. Dismiss Attendants who are not meeting their needs.

d. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.

e. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the Member's Licensed Medical Professional.

f. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and Referral process.

g. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.

h. Request a Reassessment, as defined at Section 8.7200.B.27, if Level of Care or service needs have changed.

2. An Authorized Representative is not allowed to be reimbursed for In-Home Support Services (IHSS) Attendant services for the Member they represent.

3. If the Member is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:

a. Must be at least 18 years of age.

b. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.

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

5. In-Home Support Services (IHSS) Members who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS Member.

6. The Member and their Authorized Representative must adhere to In-Home Support Services (IHSS) Agency policies and procedures.

8.7528.G In-Home Support Services Agency Eligibility

1. The In-Home Support Services (IHSS) Agency must be a licensed home care Agency. The IHSS Agency shall comply with all requirements of their Certification and licensure, in addition to requirements described in Section 8.7400.

2. Administrators or managers as defined at 6 C.C.R. 1011-1 Chapter 26 shall satisfactorily complete the Department authorized training on In-Home Support Services (IHSS) rules and regulations prior to Medicaid Certification and annually thereafter. Provider Agencies must upload the certificate of completion annually into the Medicaid Provider Portal.

8.7528.H In-Home Support Services (IHSS) Agency Responsibilities

1. The In-Home Support Services (IHSS) Agency shall assure and document that all Members are provided the following:

a. Independent Living Core Services

i. An IHSS Agency must provide a list of the full scope of Independent Living Core Services provided by the Agency to each Member on an annual basis. The IHSS Agency must keep a record of each Member’s choice to utilize or refuse these services, and document services provided.

b. Attendant training, oversight and supervision by a licensed healthcare professional.

c. The IHSS Agency shall provide 24-hour back-up service for scheduled visits to Members at any time an Attendant is not available. At the time the Care Plan is developed the IHSS Agency shall ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.

2. The In-Home Support Services (IHSS) Agency shall adhere to the following:

a. If the IHSS Agency admits Members with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the Agency or have other effective back-up plans to ensure the needs of the Member are met.

b. The IHSS Agency shall only accept Members for care or services based on a reasonable assurance that the needs of the Member can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.

i. There shall be documentation in the Care Plan or Member record of the agreed upon days and times of services to be provided based upon the Member's needs that is updated at least annually.

c. If an IHSS Agency receives a Referral of a Member who requires care or services that are not available at the time of Referral, the IHSS Agency shall advise the Member or their Authorized Representative and the Case Manager of that fact.

i. The IHSS Agency shall only admit the Member if the Member or their Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.

d. The IHSS Agency shall ensure orientation is provided to Members or Authorized Representatives who are new to IHSS or request re-orientation through the Department's prescribed process. Orientation shall include instruction in the philosophy, policies, and procedures of IHSS and information concerning Member rights and responsibilities.

e. The IHSS Agency will keep written service notes documenting the services provided at each visit.

3. The In-Home Support Services (IHSS) Agency is the legal employer of a Member's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by the Department.

4. The In-Home Support Services (IHSS) Agency shall ensure that no attendant provides more than sixteen (16) hours of care per day for one or more members collectively.

5~~4~~. The In-Home Support Services (IHSS) Agency shall assist all Members in interviewing and selecting an Attendant when requested and maintain documentation of the IHSS Agency's assistance and/or the Member's refusal of such assistance.

6~~5~~. The In-Home Support Services (IHSS) Agency will complete an intake Assessment following Referral from the Case Manager. Utilizing the authorized units provided on the IHSS Care Plan Calculator provided by the Case Manager, the IHSS Agency will develop a Care Plan in coordination with the Case Manager and Member. Any proposed services described in the Care Plan that differ from the authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to the start of services.

7~~6~~. The In-Home Support Services (IHSS) Agency shall ensure that a current Care Plan is in the Member's record, and that Care Plans are updated with the Member at least annually or more

frequently in the event of a Member's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.

a. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope, and duration of each service to be provided to the Member for each day and visit. The Care Plan shall be signed by the Member or the Member's Authorized Representative and the IHSS Agency.

i. Secondary or contiguous tasks must be described on the care plan as required in Section 8.7528.E.3.a-b.

b. In the event of the observation of new symptoms or worsening condition that may impair the Member's ability to direct their care, the IHSS Agency, in consultation with the Member or their Authorized Representative and Case Manager, shall contact the Member's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the Member's revised Care Plan, with the Member and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval.

8~~7~~. The In-Home Support Services (IHSS) Agencies Licensed Health Care Professional is responsible for the following activities:

a. Administer a skills validation test for Attendants who will perform Health Maintenance Activities. Skills validation for all assigned tasks must be completed prior to service delivery unless postponed by the Member or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS Agency in the Member's file. In no event shall the skills validation be postponed for more than thirty (30) days after services begin to prevent interruption in services.

b. Verify and document Attendant skills and competency to perform IHSS and basic Member safety procedures.

c. Counsel Attendants and staff on difficult cases and potentially dangerous situations.

d. Consult with the Member, Authorized Representative or Attendant in the event a medical issue arises.

e. Investigate Complaints and Incidents within ten (10) calendar days as required in Section 8.7411.

f. Verify the Attendant follows all tasks set forth in the Care Plan.

g. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the Member, their Authorized Representative, or the Case Manager.

h. Provide in-home supervision for the Member as recommended by their Licensed Medical Professional and as agreed upon by the Member or their Authorized Representative.

9~~8~~. At the time of enrollment and following any change of condition, the In-Home Support Services (IHSS) Agency will review recommendations for supervision listed on the Physician Attestation of

Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the Member record.

a. The IHSS Agency shall collaborate with the Member or Member's Authorized Representative to determine the level of supervision provided by the IHSS Agency's Licensed Health Care Professional beyond the requirements set forth at Section 25.5-6-1203, C.R.S.

b. The Member may decline recommendations by the Licensed Medical Professional for in-home supervision. The IHSS Agency must document this choice in the Member record and notify the Case Manager. The IHSS Agency and their Licensed Health Care Professional, Case Manager, and Member or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

10~~9~~. The In-Home Support Services (IHSS) Agency shall assure and document that all Attendants have received training in the delivery of IHSS prior to the start of services. Attendant training shall include:

a. Development of interpersonal skills focused on addressing the needs of persons with disabilities.

b. Overview of IHSS as a service-delivery option of consumer direction.

c. Instruction on basic first aid administration.

d. Instruction on safety and emergency procedures.

e. Instruction on infection control techniques, including Universal Precautions.

f. Mandatory reporting and Incident reporting procedures.

g. Skills validation test for unskilled tasks assigned on the care plan.

10. The In-Home Support Services (IHSS) Agency shall allow the Member or Authorized Representative to provide individualized Attendant training that is specific to their own needs and preferences.

11. With the support of the In-Home Support Services (IHSS) Agency, Attendants must adhere to the following:

a. Must be at least 16 years of age and demonstrate competency in caring for the Member to the satisfaction of the Member or Authorized Representative.

i. Minor attendants ages 16 to 17 will not be permitted to operate floor-based vertical powered patient/resident lift devices, ceiling-mounted vertical powered patient/resident lift devices, and powered sit-to-stand patient/resident lift devices (lifting devices).

b. May be a Family Member subject to the reimbursement and service limitations in 8.7528.J.

c. Must be able to perform the assigned tasks on the Care Plan.

d. Shall not, in exercising their duties as an In-Home Support Services (IHSS) Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse pursuant to Section 25.5-6-1203(3), C.R.S.

e. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.

12. The In-Home Support Services (IHSS) Agency shall provide functional skills training to assist Members and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

8.7528.I In-Home Support Services (IHSS) Case Management Agency Responsibilities

1. The Case Manager shall provide information and resources about In-Home Support Services (IHSS) to eligible Members, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.

2. The Case Manager will initiate a Referral to the In-Home Support Services (IHSS) Agency of the Member or Authorized Representative's choice, including an outline of approved services as determined by the Case Manager's most recent Assessment. The Referral must include the Physician Attestation, Assessment information, and other pertinent documentation to support the development of the Care Plan.

3. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:

a. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.

b. The Shared Responsibilities Form shall be completed upon enrollment and following any change of condition. If the Member requires an Authorized Representative, the Shared Responsibilities Form must include the designation and attestation of an Authorized Representative.

4. Upon the receipt of the Care Plan, the Case Manager shall:

a. Review the Care Plan within five business days of receipt to ensure there is no disruption or delay in the start of services.

b. Ensure all required information is in the Member's Care Plan and that services are appropriate given the Member's medical or functional condition. If needed, request additional information from the Member, their Authorized Representative, the In-Home Support Services (IHSS) Agency, or Licensed Medical Professional regarding services requested.

c. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.

d. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager

will document the status of recommendations and provide resources for services outside the scope of the Member's eligible benefits.

e. Collaborate with the Member or their Authorized Representative and the In-Home Support Services (IHSS) Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.

f. Authorize cost-effective and non-duplicative services via the Prior Authorization Request (PAR). Provide a copy of the Prior Authorization Request (PAR) to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.

g. Work collaboratively with the IHSS Agency, Member, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.

i. Case Managers will complete the Long-Term Care ~~Waiver~~ Program Notice of Action (LTC-803) and provide the Member or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the Member's rights to fair hearing, and appeal procedures.

5. The Case Manager shall ensure cost-effectiveness and non-duplication of services by:

a. Documenting the discontinuation of previously authorized Agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by In-Home Support Services (IHSS).

b. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.

i. A Member may receive non-duplicative services from multiple Attendants or agencies if appropriate for the Member's Level of Care and documented service needs.

c. Ensuring the Member's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan and requesting additional information as needed.

d. Coordinating transitions from a hospital, nursing facility, or other Agency to IHSS. Assisting Members with transitions from IHSS to alternate services if appropriate.

e. Collaborating with the Member or their Authorized Representative and the IHSS Agency in the event of any change in condition. The Case Manager shall request an updated Physician Attestation of Consumer Capacity form. The Case Manager may revise the Care Plan as appropriate given the Member's condition and functioning.

f. Completing a Reassessment as defined at Section 8.7200.B.27 if requested by the Member if Level of Care or service needs have changed.

6. The Case Manager shall not authorize more than one consumer-directed program on the Member's Prior Authorization Request (PAR).

7. The Case Manager shall participate in training and consultative opportunities with the Department's Consumer-Directed Training ~~& Operations~~ and Support Contractor.

8. Additional requirements for Case Managers:

a. Contact the Member or Authorized Representative once a month during the first three months of receiving In-Home Support Services (IHSS) to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.

b. Contact the Member or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.

c. Contact the Member or Authorized Representative when a change in Authorized Representative occurs and continue contact once a month for three months after the change takes place.

d. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the Agency, and supervision provided. The Case Manager must document and keep record of the following:

i. In-Home Support Services (IHSS) Care Plans;

ii. In-home supervision needs as recommended by the Physician;

iii. Independent Living Core Services offered and provided by the IHSS Agency; and

iv. Additional supports provided to the Member by the IHSS Agency.

9. Start of Services

a. Services may begin only after the requirements of Sections 8.7528.C, 8.7528.H.5, 8.7528.H.9, and 8.7528.I.3 of this rule have been met.

b. The Case Manager shall follow the Department's assessment ~~utilization management review~~ process and receive authorization prior to authorizing a start date for Attendant services for Person-Centered Support Plans that;

i. Contain Health Maintenance Activities; or

ii. Exceed the cost of care received in an institutional setting.

c. The Case Manager shall establish a service period and submit a Prior Authorization Request (PAR), providing a copy to the In-Home Support Services (IHSS) Agency prior to the start of services.

8.7528.J In-Home Support Services (IHSS) Reimbursement and Service Limitations

1. In-Home Support Services (IHSS) Personal Care services must comply with the rules for reimbursement set forth at Section 8.7538 Personal Care. IHSS Homemaker services must comply with the rules for reimbursement set forth at Section 8.7527 Homemaker Services.

2. The In-Home Support Services (IHSS) Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved Prior Authorization Request (PAR). The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless

of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.

3. The In-Home Support Services (IHSS) Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.

4. Services by an Authorized Representative to represent the Member are not reimbursable. In-Home Support Services (IHSS) services performed by an Authorized Representative for the Member that they represent are not reimbursable.

5. An In-Home Support Services (IHSS) Agency shall not be reimbursed for more than ~~twenty-four~~sixteen (16) hours of IHSS service in one day by an Attendant for one or more Members collectively.

6. A Member cannot receive In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS) at the same time.

7. Legally Responsible Persons shall not be reimbursed for more than 520 hours of homemaker services annually.

8~~7~~. Payment does not include travel time to or from the Member's residence.

8.7528.K In-Home Support Services (IHSS) Discontinuation and Termination

1. A Member may elect to discontinue In-Home Support Services (IHSS) or use an alternate service-delivery option at any time.

2. A Member may be discontinued from In-Home Support Services (IHSS) when equivalent care in the community has been secured.

3. The Case Manager may terminate a Member's participation in In-Home Support Services (IHSS) for the following reasons:

   a. The Member or their Authorized Representative fails to comply with IHSS program requirements as defined in Section 8.7528.F, or

   b. A Member no longer meets program criteria, or

   c. The Member provides false information, false records, or is convicted of fraud, or

   d. The Member or their Authorized Representative exhibits Inappropriate Behavior, and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.

      i. The IHSS Agency and Case Manager are required to assist the Member or their Authorized Representative to resolve the Inappropriate Behavior, which may include the addition of or a change of Authorized Representative. All attempts to resolve the Inappropriate Behavior must be documented prior to notice of termination.

4. When an In-Home Support Services (IHSS) Agency discontinues services, the Agency shall give the Member and the Member's Authorized Representative written notice of at least thirty days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice

shall be considered given when it is documented that the Member or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the Case Management Agency.

a. Exceptions will be made to the requirement for advanced notice when the In-Home Support Services (IHSS) Agency has documented that there is an immediate threat to the Member, IHSS Agency, or Attendants.

b. Upon In-Home Support Services (IHSS) Agency discretion, the Agency may allow the Member or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

5. If continued services are needed with another Agency, the current In-Home Support Services (IHSS) Agency shall collaborate with the Case Manager and Member or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the Member's safety and welfare.

6. In the event of discontinuation or termination from In-Home Support Services (IHSS), the Case Manager shall:

a. Complete the Long-Term Care ~~Waiver~~ Program Notice of (LTC-803) and provide the Member or the Authorized Representative with the reasons for termination, information about the Member's rights to fair hearing, and appeal procedures. Once notice has been given, the Member or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.

8.7538 Personal Care

8.7538.A Personal Care Eligibility

1. Personal Care is a covered benefit available to Members enrolled in CFC.~~one of the following HCBS waivers:~~

~~a. Brain Injury Waiver~~

~~b. Community Mental Health Supports Waiver~~

~~c. Complementary and Integrative Health Waiver~~

~~d. Elderly, Blind, and Disabled Waiver~~

~~e. Supported Living Services Waiver~~

8.7538.B Personal Care Definition

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

8.7538.C Personal Care Inclusions

1. Tasks included in Personal Care:

a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;

b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask to or from the Member's face;

c. Preventative skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays and/or solutions, and monitoring for skin changes.

d. Bladder/Bowel Care:

i. Assisting Member to and from the bathroom;

ii. Assistance with bed pans, urinals, and commodes;

iii. Changing incontinence clothing or pads;

iv. Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v. Emptying ostomy bags; and

vi. Perineal care.

e. Personal hygiene:

i. Bathing including washing, shampooing;

ii. Grooming;

iii. Shaving with an electric or safety razor;

iv. Combing and styling hair;

v. Filing and soaking nails; and

vi. Basic oral hygiene and denture care.

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints, and the application of artificial limbs when the Member is able to assist or direct.

g. Transferring a Member when the Member has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the Member and Direct Care Worker are fully trained in the use of the equipment and the Member can direct and assist with the transfer.

h. Mobility assistance when the Member has the ability to reliably balance and bear weight or when the Member is independent with an assistive device.

i. Positioning when the Member is able to verbally or nonverbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.

j. Medication Reminders when medications have been preselected by the Member, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:

i. Medication reminders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;

ii. Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the Member and opening the appropriately marked medication minder if the Member is unable to do so independently.

k. Accompanying includes the following: ~~going with the Member, as indicated on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the Member may include providing one or more personal care services as needed during the trip. A Direct Care Worker may assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the Direct Care Worker.~~

i. Going with the Member to medical appointments, as indicated on the support plan, to provide one or more personal care tasks, or assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the Direct Care Worker; and/or

ii. Going with the Member to run errands such as grocery shopping or banking and providing one or more personal care tasks as needed during the trip.

l. Homemaker Services, as described at Section 8.7527, may be provided by personal care staff, if provided during the same visit as personal care.

m. Cleaning and basic maintenance of durable medical equipment.

n. Protective Oversight is allowed when the Member requires supervision to prevent or mitigate disability, memory, or cognitive functioning-related behaviors or impairment, that may result in imminent harm to self, people, or property.~~:~~

~~i. In the HCBS Elderly, Blind, and Disabled (EBD); Brain Injury (BI); Complementary and Integrative Health (CIH); Community Mental Health Supports (CMHS) Waivers: is allowed when the Member requires stand-by assistance with any of the unskilled personal care described in these regulations, or when the Member must be supervised at all times to prevent wandering.~~

~~ii. For In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS): is allowed when the Member requires supervision to prevent or mitigate disability-related behaviors that may result in imminent harm to people or property.~~

~~iii. In the HCBS Supported Living Services (SLS) Waiver: is not allowed.~~

o. Personal Care Services includes the option for the Acquisition, Maintenance, and Enhancement of Skills (AME) task when the support is related to functional skills training

and is desired by the member to accomplish Personal Care tasks to increase their independence and reduce supports needed in the home and community.

i. Detailed, task-related goals shall be documented by case manager in the Person-Centered Support Plan, including documentation monitoring progress and any decrease in human assistance previously authorized.

ii. AME services shall include direct training and instruction to the Member in performing Personal Care tasks.

iii. The provider or attendant shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task.

~~o. Exercise:~~

~~i. In the HCBS Elderly, Blind, and Disabled (EBD) Waiver; Brain Injury (BI) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS); Supported Living Services (SLS) Waiver: is allowed when not prescribed by a Licensed Medical Professional and limited to the encouragement of normal bodily movement, as tolerated, on the part of the Member.~~

~~p. For In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS): is not allowed as a personal care service.2. Supported Living Services (SLS) Waiver:~~

~~a. In addition to the inclusions at Section 8.7538.C, personal care provided under the SLS Waiver also includes:~~

~~i. Assistance with money management,~~

~~ii. Assistance with menu planning and grocery shopping, and~~

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

8.7538.D Personal Care Exclusions and Limitations

1. ~~The following exclusions and limitations apply to the HCBS Brain Injury (BI); Elderly, Blind, and Disabled (EBD); Complementary and Integrative Health (CIH); Community Mental Health Supports (CMHS), Supported Living Services (SLS) Waivers:~~

~~a.~~ Personal care services shall not include any skilled care. Skilled care as defined under Section 8.7523, shall not be provided as personal care services under HCBS, regardless of the level of the training, certification, or supervision of the personal care employee.

2.~~b.~~ The amount of personal care that is prior authorized is only an estimate. The prior authorization includes the number of hours a Member may need for their care; the Member is not required to utilize all units, however, units over the maximum authorized are not eligible for reimbursement, All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the Member's needs.

3.~~c.~~ Personal Care Provider Agencies may decline to perform any specific task, if the supervisor or the personal care staff feels uncomfortable about the safety of the Member or the personal care staff, regardless of whether the task may be included in the definition above.

4.~~d.~~ ~~Family Members shall not be reimbursed for providing only homemaker services.~~ Family Members must provide ~~relative~~ personal care in accordance with the following:

a~~i~~. Family Members may be employed by ~~certified~~ Personal Care Agencies that are licensed and certified, as applicable to programs offered by the agency, to provide Personal Care Services to relatives enrolled a waiver subject to the conditions below.

b~~ii~~. The Family Member shall meet all requirements for employment by a ~~certified p~~Personal ~~c~~Care Agency that is licensed and certified, as applicable to programs offered by the agency, and shall be employed and supervised by the personal care Agency.

c~~iii~~. The Family Member providing personal care shall be reimbursed, an hourly rate, by the personal care Agency which employs the Family Member, with the following restrictions:

i.~~1)~~ ~~The total number of Medicaid personal care units for a Member of the Members Family shall not exceed the equivalent of 444 hours per support plan year which is equivalent to an average of 1.2164 hours a day (as indicated on the Member's support plan).~~

~~a) If the support plan year for the waiver is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the Member is receiving care by the average hours per day of personal care for a full year.~~

~~b)~~ The reimbursement for personal care units shall cover the personal care Agency's costs for unemployment insurance, worker's compensation, FICA, training and supervision, and all other administrative costs.

~~c) The above restrictions on allowable personal care units shall not apply to Members who receive personal care through Consumer Directed Attendant Support Services (CDASS), whose parents provide Attendant services to their eligible adult children through In-Home Support Services (IHSS), or who receive Personal Care through the SLS Waiver.~~

~~2) If two or more waiver Members reside in the same household, Family Members may be reimbursed up to the maximum for each Member if the services are not duplicative and are appropriate to meet the Member's needs.~~

ii.~~3)~~ When ~~waiver~~ CFC funds are utilized for reimbursement of personal care services provided by the Member's family, the home care allowance may not be used to reimburse the family.

d~~iv~~. Documentation of services provided shall indicate that the provider is a relative when services are provided by a Family Member.

5~~1~~. Billing for travel time is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.

6. Individual caregivers may not be reimbursed for more than sixteen (16) hours of care per day for one or more members collectively.

8.7538.E Personal Care Provider Agency Requirements

1. ~~For the HCBS Brain Injury (BI); Elderly, Blind, and Disabled (EBD); Complementary and Integrative Health (CIH); Community Mental Health Supports (CMHS); and Supported Living Services (SLS) Waivers:~~

~~a.~~ In addition to the training requirements described in Section 8.7400 HCBS Provider Agency Requirements, Personal Care Provider Agencies must be licensed and certified, as applicable to programs offered by the agency, through Colorado Department of Public Health and Environment. Personal Care Provider Agencies shall assure and document that all personal care staff have received at least twenty hours of training, or have passed a skills validation test, in the provision of unskilled personal care as described above. Training, or skills validation, shall include the areas of bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care, medication reminding, homemaking, and Protective Oversight. Training shall also include instruction in basic first aid, and training in infection control techniques, including Universal Precautions. Training or skills validation shall be completed prior to service delivery, except for components of training that may be provided in the Member's home, in the presence of the supervisor.

~~b~~a. All employees providing personal care shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of personal care staff, as specified above. Supervision shall include, but not be limited to, the following activities:

i. Orientation of staff to Agency policies and procedures.

ii. Arrangement and documentation of training.

iii. Informing staff of policies concerning advance directives and emergency procedures.

iv. Oversight of scheduling, and notification to Members of changes; or close communication with scheduling staff.

v. Written assignment of duties on a Member-specific basis.

vi. Meetings and conferences with staff as necessary.

vii. Supervisory visits to Member's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, Member-specific or procedure-specific training of staff, observation of Member's condition and care, and Assessment of Member's satisfaction with services. At least one of the assigned personal care staff must be present at supervisory visits at least once every three months.

1) Supervision should be flexible to the needs of the member and may be conducted via phone, video conference, telecommunication, or in-person.

a) If there is a safety concern with the services, the Provider Agency must make every effort to conduct an in-person Assessment.

b) The Provider Agency must conduct Direct Care Worker (DCW) supervision to ensure that Member care and treatment are delivered in accordance with a plan of care that addresses the Member status and needs.

viii. Investigation of Complaints and Incidents.

ix. Counseling with staff on difficult cases, and potentially dangerous situations.

x. Communication with the Case Managers, the physician, and other providers on the care plan, as necessary to assure appropriate and effective care.

xi. Oversight of record keeping by staff.

~~c~~b. A Personal Care Agency may be denied or terminated from participation in Colorado Medicaid, according to Section 8.7403. Additionally, personal care agencies may be terminated for the following:

i. Improper Billing Practices:

1) Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the Member's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.7400.

2) Billing for excessive hours that are not justified by the documentation of services provided, or by the Member's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as much time as that authorized.

3) Billing for time spent by the personal care provider performing any tasks that are not allowed according to regulations in Section 8.7538. This includes but is not limited to companionship, financial management, transporting of Members, skilled personal care, or delegated nursing tasks.

4) Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker Agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

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

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

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

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

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

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

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

6) Billing for travel time Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.

ii. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services Without Also Receiving Payment for Home Health Services.

1) A personal care/homemaker agency that is also certified as a Medicaid Home Health Agency may be terminated from Medicaid participation if the agency refuses to provide necessary and allowed HCBS personal care or homemaker services to Members who do not need Home Health services or who receive their Home Health services from a Home Health Agency not affiliated with the personal care/homemaker agency.

iii. Prior Termination from Medicaid Participation.

1) A personal care/homemaker agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have been previously involuntarily terminated from Medicaid participation, regardless of the provider type of the entity that was terminated.

iv. Abrupt Prior Closure.

1) A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed without proper prior Member notification regardless of the provider type of the entity that closed abruptly.

8.7538.F Personal Care Reimbursement Requirements

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

~~a.~~ Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of ~~one hour~~15 minutes. The maximum unit rate shall be adjusted by the State as funding becomes available.

2.~~b.~~ Payment does not include travel time to or from the Member's residence.

3.~~c.~~ When personal care services are used to provide respite for unpaid primary caregivers, the exact services rendered must be specified in the documentation.

4. ~~d.~~If a visit by a personal care staff includes some homemaker and personal care services, the ~~entire~~ visit shall be ~~billed~~ billed separately in accordance with services provided.~~as personal care services. If the visit includes only homemaker services, and no personal care is provided, the entire visit shall be billed as homemaker services.~~

5.~~e.~~ If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.~~f.~~

6. There shall be no reimbursement under this section for personal care services provided in certified, uncertified, licensed, or unlicensed Congregate Facilities.

8.7544 Remote Supports

8.7544.A Remote Supports Eligibility

1. Remote Supports is a covered benefit available to Members enrolled in CFC.~~one of the following HCBS waivers:~~

~~a. Brain Injury Waiver~~

~~b. Community Mental Health Supports Waiver~~

~~c. Complementary and Integrative Health Waiver~~

~~d. Elderly, Blind, and Disabled Waiver~~

~~e. Supported Living Services Waiver~~

8.7544.B Remote Support Definitions

1. Backup Support Person means the person who is responsible for responding in the event of an emergency or when a Member receiving Remote Supports otherwise needs assistance or the equipment used for delivery of Remote Supports stops working for any reason.

2. Monitoring Base means the off-site location from which the Remote Supports Provider monitors the Member.

3. Remote Supports means the provision of support by staff at a HIPAA compliant Monitoring Base who engage with a Member through live two-way communication to provide prompts and respond to the Member's health, safety, and other needs identified through a Person-Centered Support Plan to increase their independence in their home and community when not engaged in other HCBS services.

4. Remote Supports Service Plan means a document that describes the Member's need for remote support, devices that will be used, number of service hours, emergency contacts, and a safety plan developed between the Member and Remote Supports Provider Agency in consultation with their Case Manager.

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

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

8.7544.C Remote Supports Inclusions

1. Remote Supports that help a Member with Activities of Daily Living and Iinstrumental Aactivities of Ddaily Lliving tasks that can be completed through virtual two-way live communication with prompts, supervision, or coaching from a Remote Supports Provider are a covered benefit.

2. Remote Supports includes prompting, coaching, and virtual supervision with Activities of Daily Living and Instrumental Activities of Daily Living either in a Member's home or community that are documented in the Member's Remote Supports Service Plan.

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

a. Motion sensing system;

b. Radio frequency identification;

c. Live audio feed;

d. Web-based system; or,

e. Another device that facilitates two-way communication.

4. Remote Supports includes the following general provisions:

a. Remote Supports shall only be approved when it is the Member's preference and will reduce the assessed need for in-person care.

b. The Member, their Case Manager, and the selected Remote Supports Provider shall determine whether Remote Supports is sufficient to ensure the Member's health and welfare.

c. Remote Supports shall be provided in real time by awake staff at a Monitoring Base using the appropriate technology. While Remote Supports is being provided, the Remote Supports staff shall not have duties other than the provision of Remote Supports.

8.7544.D~~.~~ Remote Supports Exclusions and Non-Benefit Items

1. Remote Supports shall be authorized ~~only~~ for Members who have the physical and mental capacity to utilize the particular system(s) that meet needs identified during the person-centered planning process, and which the Member prefers to be met with virtual support. ~~requested for that Member~~.

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

3. Remote Supports shall not be performed concurrently or be duplicative of any other HCBS benefit or service.

4, Remote Supports shall not provide any service that is authorized for Telehealth at Section 8.7562.

5. Remote Supports Technology shall only be used for the delivery of Remote Supports.

6. Remote Supports is available to Members to foster developmentally appropriate independence and not to replace informal support.

7. Video or audio monitoring and recording is not allowed. Interactions between the Remote Support Provider and the Member should be through live, two-way communication that is on-demand, scheduled, or alerted by a sensor as agreed to by the Member in the Remote Supports Service Plan.

8. Devices used for communication shall not be mounted in a bedroom or bathroom and must be able to be moved by the Member to a location of their choice.

9. The following are not benefits of Remote Supports:

a. The cost of meals, household supplies, cell phones, internet access, landline telephone lines, and cellular phone voice or data plans.

b. Augmentative communication devices and communication boards;

c. Hearing aids and accessories;

d. Phonic ears;

e. Environmental control units;

f. Computers and computer software unrelated to the provision of Remote Supports;

g. Wheelchair lifts for automobiles or vans;

h. Exercise equipment, such as exercise cycles;

i. Hot tubs, Jacuzzis, or similar items.

8.7544.E Remote Supports Provider Agency Requirements

1. The Remote Supports Provider must comply with the Provider Agency Regulations at Section 8.7400 et seq. and the provider enrollment agreement.

2. The Remote Supports Provider shall meet with the Member to identify Remote Supports service needs and develop services in a Remote Supports Service Plan that will be sent to the Member's Case Manager. The Remote Supports Care Plan must include:

   a. The location(s) where the Member will receive the service,

   b. A description of tasks/services the Remote Supports Provider will perform for the Member,

   c. The technology devices determined necessary to help the Member meet their identified need

   d. Family or providers with whom the Member has authorized the Remote Supports Provider to share information with and a safety plan that includes emergency contact information and medical conditions, if any, that should be shared with emergency response personnel if the provider must contact them, and

   e. An up-to-date list of Backup Support Person(s). Backup support may be provided on an unpaid basis by a Family Member, friend, or other person selected by the Member or on a paid basis by an Agency provider.

3. Remote Supports Providers shall conform to the following standards for electronic monitoring services:

   a. Properly trained individuals shall install all equipment, materials, or appliances, and the installer and/or provider of electronic monitoring shall train the Member in the use of the device.

   b. All equipment, materials, or appliances shall be tested for proper functioning at the time of installation, and at periodic intervals after that, and be maintained based on the manufacturer's recommendations. Any malfunction shall be promptly repaired, and equipment replaced when necessary, including buttons and batteries.

c. All telephone calls generated by monitoring equipment shall be toll-free, and all Members shall be allowed to run unrestricted tests on their equipment.

d. Remote Supports Providers shall send written information to each Member's Case Manager about the system, how it works, and how it will be maintained in the Remote Support Plan.

e. The Remote Support Provider shall provide a Member who receives Remote Supports with initial and ongoing training on how to use the Remote Supports system(s) including regular confirmation that the Member knows how to turn systems on and off.

4. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.

5. The Remote Supports Provider shall have a backup power system (such as battery power and/or generator) in place at the Monitoring Base in the event of electrical outages. The Remote Supports Provider shall have additional backup systems and additional safeguards in place which shall include, but are not limited to, contacting the Backup Support Person in the event the Monitoring Base System stops working for any reason.

6. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.

7. If a known or reported emergency involving a Member arises, the Remote Supports Provider shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the Backup Support Person. The Remote Supports Provider shall maintain contact with the Member during an emergency until emergency personnel or the Backup Support Person arrives.

8. The Backup Support Person shall verbally acknowledge receipt of a request for assistance from the Remote Supports Provider. Text messages, email, or voicemail messages will not be accepted as verbal acknowledgment.

9. When a Member requests in-person assistance, the Backup Support Person shall arrive at the Member's location within a reasonable amount of time based on team agreement to be specified in documentation maintained by the Remote Support Provider.

10. When a Member needs assistance, but the situation is not an emergency, the Remote Supports Provider shall:

a. Address the situation from the Monitoring Base, or,

b. Contact the Member’s Backup Support Person if necessary.

11. The Remote Support Provider shall maintain detailed and current written protocols for responding to a Member's needs, including contact information for the Backup Support Person to provide assistance.

12. The Remote Support Provider shall maintain documentation of the protocol to be followed should the Member request that the equipment used for delivery of Remote Supports be turned off.

13. The Remote Supports Provider shall maintain daily service provision documentation that shall include the following:

a. Type of Service,

b. Date of Service,

c. Place of Service,

d. Name of Member receiving service,

e. Medicaid identification number of Member receiving service,

f. Name of Remote Supports Provider,

g. Identify the Backup Support Person and their contact information, if/when utilized.

h. Begin and end time of the Remote Supports service,

i. Begin and end time of the Remote Supports service when a Backup Support Person is needed on site,

j. Begin and end time of the Backup Support Person when on site, whether paid or unpaid,

k. Number of units of Remote Supports service delivered per calendar day,

l. Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the Member's current Person-Center Support Plan, which shall be communicated to the Member's Case Manager.

8.7544.F Remote Supports Reimbursement

1. For Remote Supports, the reimbursement unit shall include one unit per installation/equipment purchase and/or the units as designated on the Department's fee schedule and/or billing manuals for ongoing Remote Supports service.

2. Remote Supports in Provider -Owned, -Controlled, or Congregate Facility settings are not eligible for reimbursement by the Colorado Medicaid program.

8.7552 Transition Setup

8.7552.A Transition Setup Eligibility

1. Transition Setup is a covered benefit available to Members enrolled in CFC. ~~one of the following HCBS waivers:~~

~~a. Brain Injury Waiver~~

~~b. Community Mental Health Supports Waiver~~

~~c. Complementary and Integrative Health Waiver~~

~~d. Developmental Disabilities Waiver~~

~~e. Elderly, Blind, and Disabled Waiver~~

~~f. Supported Living Services Waiver~~

8.7552.B Transition Setup Definition

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

8.7552.C Transition Setup Inclusions

1. Transition Setup assists the Member by coordinating the purchase of items or services needed to establish a basic household and to ensure the home environment is ready for move-in with all applicable furnishings set up and operable; and

2. Transition Setup allows up to $2000 in reimbursement for the purchase of one-time, non-recurring expenses necessary for a Member to establish a basic household as they transition from an institutional setting to a community setting. The Department may authorize additional funds above the $2,000 limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member. Allowable expenses include:

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

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

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

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

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

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

8.7552.D Transition Setup Service Access and Authorization

1. To access Transition Setup, a Member must be transitioning from an institutional setting or Regional Center to a community living arrangement and participate in a needs-based Assessment through which they demonstrate a need for the service based on the following:

    a. The Member demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a Member to establish a basic household in the community;

    b. The need demonstrates risk to the Member’s health, safety, or ability to live in the community; or

    c. Other services/resources to meet need are not available.

2. The Member ’s assessed need must be documented in the Member ’s Transition Plan and Person-Centered Support Plan.

8.7552.E Transition Setup Exclusions and Limitations

1. Transition Setup may be used to coordinate or purchase one-time, non-recurring expenses up to thirty (30) days post-transition.

2. Transition Setup does not substitute for services available under the Medicaid State Plan, other Waiver Services, or other resources.

3. Transition Setup is not available to a Member transitioning to, or residing in, a provider-owned or provider-controlled setting.

4. Transition Setup does not include payment for room and board.

5. Transition Setup does not include rental or mortgage expenses, ongoing food costs, regular utility charges, cable or satellite services.

6. Transition Setup is not available for a transition to a living arrangement that does not match or exceed HUD certification criteria.

7. Transition Setup does not include appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television, gaming, or video equipment).

8.7552.F Transition Setup Provider Agency Requirements

1. The Provider Agency shall ensure all products and services delivered to the Member shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

8.7552.G Transition Setup Documentation

1. The Provider Agency must maintain receipts for all services and/or items procured for the Member. These must be attached to the claim and noted on the Prior Authorization Request.

2. Provider Agencies must submit to the Case Management Agency the minimum documentation of the transition process, which includes:

    a. A Transition Services Referral Form,

    b. Release of Information (confidentiality) Forms, and

    c. A Transition Setup Authorization Request Form.

3. The Provider Agency must furnish to the Member a receipt for any services or durable goods purchased on the Member’s behalf.

8.7552.H Transition Setup Provider Agency Reimbursement

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

2. Transition Setup Expenses must not exceed $2000 per eligible Member. The Department may authorize additional funds above the $2000 limit, up to $2,500, when the Member demonstrates additional needs, and if the expense(s) would ensure the Member's health, safety and welfare.

3. Reimbursement shall be made only for items or services described in the Provider Care Plan with accompanying receipts.

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

8.7600 Community First Choice

8.7600.A Community First Choice (CFC) Program

1. The Community First Choice Program is funded through an appropriation from the Colorado General Assembly and the Federal government. The CFC program is designed to provide select Hhome and Ccommunity-Bbased Sservices and Ssupports to eligible members on the State Plan.

2. Legal authority as defined in 8.7000.A.

8.7601 General CFC Provisions

1. CFC must be provided to individuals on a statewide basis and in a manner that provides services and supports in the most integrated setting appropriate to meet individuals' needs, and without regard for the individual's age, type or nature of disability, severity of disability, or the form of home and community-based services and supports that the individual requires to lead an independent life.

2. Individuals receiving services through CFC will not be precluded from receiving other home and community-based or long-term care services and supports through other Medicaid state plan, waiver, grant or demonstration authorities, as long as there is no duplication of services.

3. For the duration of the first year of CFC implementation, Case Managers shall assess current HCBS waiver members for CFC eligibility and services at the time of Continued Stay Review. Case Managers may assess current HCBS waiver members prior to the scheduled Continued Stay Review as warranted by a documented change in the member's needs, diagnosis, or condition.

8.7602 CFC Member Rights and Responsibilities

1. CFC must adhere to all requirements in Home and Community-Based Services Member Rights and Responsibilities as defined in 8.7001 et seq.

8.7603 CFC Definitions

1. Activities of Daily Living is as defined at Section 8.7100.A.1.

2. Assessment is as defined at Section 8.7200.B.1

3. Case Management is as defined at Section 8.7100.A.7.

4. Case Management Agency (CMA) is as defined at Section 8.7100.A.8.

5. Member, for purposes of this Section 8.7600, et seq. means an individual who has met CFC eligibility requirements and has been offered and agreed to receive CFC Services.

6. Community First Choice (CFC) is as defined at Section 8.7001.A.1-A.

7. Continued Stay Review is as defined at Section 8.7100.A.14.

8. Institution is as defined at Section 8.7100.A.39.

9. Level of Care (LOC) is as defined at Section 8.7100.A.43.

10. Level of Care Assessment is as defined at Section 8.7100.A.44.

11. Long-Term Services and Supports (LTSS) is as defined at Section 8.7100.A.47.

12. Medicaid Eligible is as defined at Section 8.7100.A.48.

13. Reassessment is as defined at Section 8.7100.A.55.

14. Referral is as defined at Section 8.7100.A.56.

8.7604 CFC Member Eligibility

1. Individuals of all ages shall be eligible for CFC if they meet Level of Care and financial eligibility criteria.

   a. CFC is available to individuals who, absent the provision of home and community-based attendant services and supports provided under CFC, would require the level of care furnished in a:

      i. Nursing Facility;

      ii. Intermediate Care Facility;

      iii. In Patient Psychiatric Facility for Individuals under 21; or

      iv. Hospital

   b. Financial Eligibility Criteria: To be eligible for the CFC Benefit, an individual shall meet one of the following eligibility groups:

      i. Members shall meet Medicaid Assistance eligibility criteria as stated at Section 8.100 and be enrolled in a Medicaid eligibility group that includes nursing facility services.

         1) CFC does not qualify as a Health First Colorado eligibility group.

      ii. Members eligible for, and enrolled in, an HCBS Waiver ~~and enrolled in,~~ as defined in 8.7000~~101.H~~, will be eligible for CFC.

2. Level of Care determination process

   a. Individuals shall be referred to the Case Management Agency for an initial Long-Term Services and Supports (LTSS) eligibility determination. The LTSS Level of Care (LOC) eligibility determination screen as defined in 8.401 is used to determine an individual's need for institutional Level of Care.

b. The state-prescribed Assessment instrument as defined in 8.401 shall measure six defined Activities of Daily Living (ADLs) and the need for supervision for behavioral, executive or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating.

c. Level of Care Assessments and Reassessments shall be performed by Case Management Agencies and utilize the same instrument in determining the Level of Care for all LTSS programs.

~~d. For initial Level of Care eligibility determinations, the Professional Medical Information Page (PMIP) shall be completed by a treating medical professional who verifies the individual's qualifying diagnosis or conditions.~~

d. The individual must require Long-Term Services and Supports to remain in their own home, in the family residence, or in the community.

e. To utilize CFC Services, the individual must choose to receive services in their home or community.

f. The Case Management Agency shall certify CFC eligibility only for those individuals determined by a Level of Care Assessment to require the Level of Care available in an Institution according to Section 8.401.

3. Institutional Status

a. Members who are residents of Institutions are not eligible for CFC Services while residing in such Institutions.

b. A Member enrolled in CFC and who is admitted to a hospital may not receive CFC Services while residing in the hospital.

i. Providers shall not be reimbursed for CFC Services provided while the member is in a hospital.

c. A Member enrolled in CFC and who is admitted to a nursing facility or ICF-IID may not receive CFC Services while in the nursing facility or Intermediate Care Facilities.

4. Maintenance of CFC Eligibility

a. Reevaluation of the Member to verify Medicaid, financial, and program eligibility is required within twelve months following any previous Assessment. The Continued Stay Review will follow the same procedures set forth at Section 8.401.11-.17(H).

5. Termination

a. The Department shall discontinue a member's enrollment in the CFC benefit when one of the following occurs:

i. The Member no longer meets the CFC Benefit Level of Care and/or Financial eligibility criteria,

ii. The member dies,

iii. The member is admitted for a long-term stay beyond one month in an Institution, or

iv. The member voluntarily withdraws from the CFC program.

8.7605 CFC Case Management Agency Requirements

1. Case Management Agencies must adhere to all Home and Community-based Services requirements as defined at Section 8.7200, et seq.

8.7606 CFC Provider Requirements

1. CFC providers must adhere to all Home and Community-Based Services Provider Agency Requirements as defined at 8.7400, et seq.

8.7607 CFC Covered Services

1. CFC includes the following Home and Community-Based Services as defined at Section 8.7500, et seq. Services include:

a. Electronic Monitoring as defined at Section 8.7520, et seq.

b. Health Maintenance Activities as described at Section 8.7523, et seq.

c. Home Delivered Meals as defined at Section 8.7526, et seq.

d. Homemaker as defined at Section 8.7527, et seq.

e. Personal Care as defined at Section 8.7538, et seq.

f. Remote Supports as defined at Section 8.7544, et seq.

g. Transition Setup as defined at Section 8.7552, et seq.

8.7608 CFC Service Delivery Models

1. CFC members may utilize a Provider Agency defined at 8.7001.A.12-B. to receive Personal Care and Homemaker.

2. CFC members may utilize one of the following self-directed service delivery models to receive Personal Care, Homemaker, and/or Health Maintenance Activities:

a. Consumer Directed Attendant Support Services defined at 8.7515., or

b. In-Home Support Services defined at 8.7528.

3. CFC members cannot utilize Consumer Directed Attendant Support Services and In-Home Support Services/Provider Agency services simultaneously. In-Home Support and Services can be used in conjunction with Provider Agency services, as long as there is no duplication.