8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

~~8.486.60 POST-ELIGIBILITY TREATMENT OF INCOME (PETI)~~

~~A. Definition~~

~~1. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the member's obligation (payment) for the payment of residential services.~~

~~B. Post Eligibility Treatment of Income Application~~

~~2. When a member has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, the Departmeyont may reduce the Medicaid payment for Alternative Care Facility services according to the procedures set forth in this section.~~

~~3.PETI is required for Medicaid members residing in Alternative Care Facilities under the Home and Community Based Services (HCBS) Elderly, Blind, and Disabled (EBD) waiver.~~

~~C. Case Management Responsibilities~~

~~1. For 300% eligible members who reside in an Alternative Care Facility (ACF) , the case manager shall complete a State-prescribed form, which calculates the member payment according to the following procedures:~~

~~a. The member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long-Term Care (LTC) Insurance amount.~~

~~b. The member's Room and Board amount shall be deducted from the gross income and paid to the provider.~~

~~c. The member's Personal Needs Allowance (PNA) amount is based upon a member's gross income, up to the maximum amount set by the Department.~~

~~d. For an individual with financial responsibility for only a spouse, the amount protected under Spousal Protection as defined in Section 8.100.7 K shall be deducted from the member's gross income.~~

~~e. If the member is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding pan-time employment earnings of dependent children as defined at Section 8.100.1) shall be deducted from the members gross income.~~

~~f. Amounts for incurred expenses for medical or remedial care for the member that are not covered by Medicare, Medicaid, or other third party, shall be deducted from the member's gross income as follows:~~

~~i. Health insurance premiums, deductibles or co-insurance charges if health insurance coverage is documented; and~~

~~ii. Necessary dental care not to exceed amounts equal to actual expenses incurred; and~~

iii. Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred; and

iv. Medications, with the following limitations:

1) The member has a prescription for the medication.

2)

3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price, unless the prescriber has specifically prescribed a name brand medication over the generic formula.

5)

g. Other necessary medical or remedial care or items shall be deducted from the member's gross income, with the following limitations:

i. The need for such care must be documented in writing by the attending physician. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

ii. Any service, supply or equipment that is available under the Medicaid State Plan, with or without prior authorization, shall not be allowed as a deduction.

h. Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

i. If the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

j. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the member’s gross income.

k. Any remaining income shall be applied to the cost of the Alternative Care Facility services, as defined at Section 8.495, and shall be paid by the member directly to the provider.

l. If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the member's income, the remaining income shall be kept by the member and may be used at the member’s discretion.

2. At the beginning of each support plan year and whenever there is a significant change to a member’s payment obligation, the case managers shall inform the HCBS Alternative Care Facility member of their payment obligations in a manner prescribed by the Department.

a. Significant change is defined as fifty dollars ($50) or more.

3. Copies of member payment forms shall be kept in the member files at the case management agency. A copy of the form may be requested by the Department for monitoring purposes.

8.500.18 CLIENT PAYMENT - POST ELIGIBILITY TREATMENT OF INCOME

8.500.18.A A Client who is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard at Section 8.100.7.A, is required to pay a portion of the Client's income toward the cost of the Client's HCBS-DD services after allowable income deductions.

8.500.18.B This Post Eligibility Treatment of Income(PETI) assessment shall:

1. Be calculated by the Case Management Agency using the form specified by the Operating Agency.

2. Be calculated during the Client's initial or continued stay review for HCB-DD services;

3. Be recomputed as often as needed, by the case management agency in order to ensure the Client's continued eligibility for the HCBS-DD waiver;

8.500.18.C In calculating PETI assessment, the case management agency must deduct the following amounts, in the following order, from the individual's total income including amounts disregarded in determining Medicaid eligibility:

1. A maintenance allowance equal to 300% the current and/SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty five dollars ($245) per month;

2. For a Client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

3. For a Client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate TANF grant level; and

4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

a. Health insurance premiums (other than Medicare), deductibles. or coinsurance charges (including Medicaid copayments); and

b. Necessary medical or remedial care recognized under State law but not covered under the Medicaid State Plan.

8.500.18.D Case Management Agencies are responsible for informing individuals of their PETI obligation on a form prescribed by the Operating Agency.

8.500.18.E PETI payments and the corresponding assessment forms are due to the Operating Agency during the month following the month for which they are assessed.

8.500.108 CLIENT PAYMENT-POST ELIGIBILITY TREATMENT OF INCOME

8.500.108.A A Client who is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard at Section 8.1100.7, is required to pay a portion of the Client's income toward the cost of the Client's HCBS-SLS services after allowable income deductions.

8.500.108.B This post eligibility treatment of income (PETI) assessment shall:

1. Be calculated by the case management agency during the Client's initial assessment and continued stay review for HCBS-SLS services.

2. Be recomputed, as often as needed, by the case management agency in order to ensure the Client's continued eligibility for the HCBS-SLS waiver

8.500.108.C In calculating PETI assessment, the case management agency must deduct the following amounts, in the following order, from the Client's total income including amounts disregarded in determining Medicaid eligibility:

1. A maintenance allowance equal to three hundred percent (300%) of the current SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty-five dollars ($245) per month; and

2. For a Client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

3. For a Client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate TANF grant level; and

4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

a. Health insurance premiums (other than Medicare), deductibles. or coinsurance charges, (including Medicaid copayments)

b. Necessary medical or remedial care recognized under state law but not covered under the Medicaid State Plan.

8.500.108.D Case management agencies are responsible for informing Clients of their PETI obligation on a form prescribed by the Operating Agency.

8.500.108.E PETI payments and the corresponding assessment forms are due to the Operation Agency during the month following the month for which they are assessed.

8.505 INCREASE OF THE REIMBURSEMENT RATE RESERVED FOR COMPENSATION OF DIRECT SUPPORT PROFESSIONALS

8.505.1 DEFINITIONS

Definitions below only apply to Section 8.505.

A. Compensation means any form of monetary payment, including bonuses, employer-paid health and other insurance programs, paid time off, payroll taxes that are proportionate to the increase in compensation, and all other fixed and variable benefits conferred on or received by all direct support professionals providing services as enumerated below.

B. Direct Support Professional means a worker who assists or supervises a worker to assist a person with intellectual and developmental disabilities to lead a fulfilling life in the community through a diverse range of services, including helping the person get ready in the morning, take medication, go to work or find work, and participate in social activities. Direct Support Professional includes all workers categorized as program direct support professionals and excludes workers categorized as administrative, as defined in standards established by the financial accounting standards board.

C. Direct Benefit means compensation that is directly conferred onto a direct support professional for their sole benefit and does not include direct benefits to the employing or contracting service agency which may have an indirect benefit to the direct support professional.

D. Plan of Correction means a formal, written response from a employing or contracting service agency to the Department on identified areas of non-compliance with requirements listed at Section 25.5-6-406, C.R.S. or Section 8.505.

E. Payroll tax means taxes that are paid or withheld by the employer on the employee's behalf such as Social Security tax, Medicare tax, and Medicare surtax.

8.505.2 REIMBURSEMENT RATE INCREASE

A. Effective March 1, 2019, the Department increased reimbursement rates by six and a half percent which is to be reserved for compensation to direct support professionals above the rate of compensation that the direct support professionals received as of June 30, 2018. The six and a half percent rate increase must be used as a direct benefit for the direct support professional within 60 days from the close of the State Fiscal Year. The following services delivered through Home and Community-based Waivers for Persons with Developmental Disabilities, Supported Living Services, and Children's Extensive Supports will receive the six and half percent increase to reimbursement rates:

1. Group Residential Services and Supports;

2. Individual Residential Services and Supports;

3. Specialized Habilitation;

4. Respite;

5. Homemaker Basic;

6. Homemaker Enhanced;

7. Personal Care;

8. Prevocational Services;

9. Behavioral Line Staff;

10. Community Connector;

11. Supported Community Connections;

12. Mentorship;

13. Supported Employment- Job Development; And

14. Supported Employment- Job Coaching.

B. Funding from the reimbursement rate increase may not be used for the following:

1. Executive Salaries

2. Administrative Expenses

3. Human Resource Expenses

4. Information Technology

5. Oversight Expenses

6. Business Management Expenses

7. General Record Keeping Expenses

8. Budget and Finance Expenses

9. Workers' Compensation Insurance

10. Contract Staffing Agency Expenses

11. Employee Appreciation Events

12. Gifts

13. Activities not identifiable to a single program.

8.505.3 REPORTING REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONAL RATE INCREASE

A. On or before December 31, 2019, and two (2) years thereafter, employing or contracting service agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-406, C.R.S. were used, including information about increased compensation for all Direct Support Professionals, how the employing or contracting service agency maintained the increase, and how the employing or contracting service agency stabilized the direct support professional workforce.

1. The employing or contracting service agencies must report to the Department, in the manner prescribed by the Department, by December 31 of each year.

2. The Department has ongoing discretion to request information from service agencies demonstrating how they maintained increases in compensation for Direct Support Professionals beyond the reporting period.

3. Failure to provide adequate and timely reports may result in recoupment of the funds.

8.505.4 AUDITING REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONAL RATE INCREASE FOR COMPENSATION

A. Each employing or contracted service agency shall keep true and accurate work records to support and demonstrate use of the funds. Such records shall be retained for a period of not less than three (3) years and shall be open to inspection by the Department and are made available to be copied by the Department or its authorized representatives at any reasonable time and as often as may be necessary.

B. Employing or contracting service agencies shall submit to the Department upon request, all records showing that the funds were used as a direct benefit for Direct Support Professionals, including but not limited to:

1. Federal Employment Forms

a. W2's -Wage and Tax Statement

b. W3 -Transmittal of Wage and Tax Statement

c. 941's -Employer's Quarterly Federal Tax Return

d. 940 -Employer's Annual Federal Tax Return

2. State Employment Forms

a. UITR 1's – State Unemployment Insurance Tax Report

b. UITR 1A's - State Unemployment Insurance Tax Report Wage List

3. Business/Corporate Tax Returns

4. Independent Contractor Forms

a. 1099's- Miscellaneous Income

b. 1096 - Annual Summary and Transmittal of U.S. Information Returns

5. Payroll Records

a. Payroll Detail

b. Payroll Summary

6. Accounting Records

a. Chart of Accounts

b. General Ledger

c. Profit & Loss Statements

d. Check Register

7. Bank Statements

8. Timesheets

9. Benefits Records

a. Health Insurance Records

b. Other Insurance Records

c. Paid Time Off Records

C. In the event that a Direct Support Professional was hired after June 30, 2018, the employing or contracting service agency shall use the lowest compensation paid to a Direct Support Professional of similar functions and duties as of June 30th, 2018. This is the base rate that the increased compensation will be applied to.

D. If the Department determines that the employing or contracting service agency did not use the increased funding as a direct benefit to the Direct Support Professional, within one year after the close of each reporting period, the Department shall notify the service agency in writing of the Department's intention to recoup funds. The service agency has forty-five (45) days after issuance of the notice of the determination to complete any of the following actions:

1. challenge the determination of the Department;

2. provide additional information to the Department demonstrating compliance;

3. submit a Plan of Correction to the Department.

E. When the Department determines that an employing or contracting service agency is not in compliance, a Plan of Correction shall be developed, upon written notification by the Department. A Plan of Correction shall include, but not be limited to:

1. A detailed description of actions to be taken to resolve issues and supporting documentation demonstrating completion.

2. A detailed timeframe specifying the actions to be taken.

3. Employee(s) responsible for implementing the actions.

4. The implementation timeframes and date(s) for completion.

F. The employing or contracting service agency must submit the Plan of Correction to the Department within forty-five (45) business days of the issuance of a written request from the Department. The employing or contracting service agency must notify the Department in writing, within five (5) business days of the receipt of the written request from the Department, if it will not be able to submit the Plan of Correction by the due date. The employing or contracting service agency must explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the employing or contracting service agency's compliance.

G. Upon receipt of the Plan of Correction, the Department will accept, request modifications, or reject the proposed Plan of Correction. Modifications or rejections will be accompanied by a written explanation. If a Plan of Correction is rejected, the employing or contracting service agency must resubmit a new Plan of Correction along with any requested documentation to the Department for review within five (5) business days of notification.

H. The Department shall notify the employing or contracting service agency in writing of its final determination after affording the employing or contracting service agency the opportunity to take the actions specified in Section 8.505.4.E. The Department shall recoup one hundred percent of the increased funding received but did not use for a direct benefit for direct support professionals if the employing or contracting service agency:

1. fails to respond to a notice of determination of the Department within the time provided in Section 8.505.4.E;

2. is unable to provide documentation of compliance; or

3. the Department does not accept the Plan of Correction submitted by the service agency, or is not completed within the established timeframe pursuant to Section 8.505.4.F.

I. All recoveries will be conducted pursuant to Section 25.5-4-301 and Section 8.076.3.

8.507 INCREASE OF THE REIMBURSEMENT RATE RESERVED FOR COMPENSATION OF DIRECT CARE WORKERS

8.507.1 DEFINITIONS

Definitions below only apply to Section 8.507.

A. Compensation means any form of monetary payment, including bonuses, employer-paid health and other insurance programs, paid time off, payroll taxes that are proportionate to the increase in compensation, and all other fixed and variable benefits conferred on or received by all Direct Care Workers providing services as enumerated below.

B. Direct Benefit means compensation that is directly conferred onto Direct Care Workers for their sole benefit and does not include direct benefits to the Home Care Agency which may have an indirect benefit to the Direct Care Workers.

C. Direct Care Worker means a non-administrative employee of a Home Care Agency who assists persons receiving personal care, homemaking, and/or In-Home Support Services in the home or community.

D. Home Care Agency means any sole proprietorship, partnership, association, corporation, government or governmental subdivision or agency subject to the restrictions in Section 25-1.5-103 (1)(a)(II), C.R.S., not-for-profit agency, or any other legal or commercial entity that manages and offers, directly or by contract, skilled home health services or personal care services to a home care consumer in the home care consumer's temporary or permanent home or place of residence. For the purposes of this section, home care agency includes only agencies providing the waiver services listed in Section 8.507.2(A) without regard to whether the agency is licensed to provide such services.

E. Payroll tax means taxes that are paid or withheld by the employer on the employee's behalf such as Social Security tax, Medicare tax, and Medicare surtax.

F. Plan of Correction means a formal, written response from a Home Care Agency to the Department on identified areas of non-compliance with requirements listed at Section 25.5-6-1602-1603, C.R.S.

8.507.2 REIMBURSEMENT RATE INCREASE

A. Effective January 1, 2020, the Department increased reimbursement rates by eight and one-tenth percent which is to be reserved for compensation to Direct Care Workers above the rate of compensation that the Direct Care Workers received as of June 30, 2019. One hundred percent of the eight and one-tenth percent rate increase must be used as compensation for the Direct Care Workers. The following services delivered through Home and Community-based Waivers will receive the eight and one-tenth percent increase to reimbursement rates:

1. Homemaker Basic

2. Homemaker Enhanced

3. Personal Care

4. In-Home Support Services

a. Exclusion: Health Maintenance Activities

B. Consumer Directed Attendant Support Services (CDASS) and Pediatric Personal Care are excluded from this Section 8.507

C. Items or expenses for which funding from the 2019-20 fiscal year reimbursement rate increase may not be used for, include, but are not limited to, the following:

1. Executive Salaries

2. Administrative Expenses

3. Human Resource Expenses

4. Information Technology

5. Oversight Expenses

6. Business Management Expenses

7. General Record Keeping Expenses

8. Budget and Finance Expenses

9. Workers' Compensation Insurance

10. Contract Staffing Agency Expenses

11. Employee Appreciation Events

12. Gifts

13. Activities not identifiable to a single program.

D. In the event that a Direct Care Worker was hired after June 30, 2019, the Home Care Agency shall use the lowest compensation paid to a Direct Care Worker of similar functions and duties as of June 30th, 2019. This is the base rate that the increased compensation will be applied to.

E. On and after July 1, 2020, the hourly minimum wage for Direct Care Workers providing personal care services, homemaker services, and In-Home Support Services is $12.41 per hour.

F. For any increase to the reimbursement rates for the above services that takes effect during the 2020-21 fiscal year, agencies shall use eighty-five percent of the funding to increase compensation for Direct Care Workers above the rate of compensation that the Direct Care Workers received as of June 30, 2020.

1. Home Care Agencies may use any remaining funding resulting from the reimbursement rate increase for general and administrative expenses, such as chief executive office salaries, human resources, information technology, oversight, business management, general record keeping, budgeting and finance, and other activities not identifiable to a single program.

G. Within sixty days after rate increases are approved, each Home Care Agency shall provide written notification to each Direct Care Worker who provides the above services of the compensation they are entitled to.

8.507.3 REPORTING REQUIREMENTS FOR DIRECT CARE WORKER RATE INCREASES

A. On or before December 31, 2020, and one (1) year thereafter, Home Care Agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-1602, C.R.S. were used to increase compensation for Direct Care Workers in the 2019-20 fiscal year. On or before December 31, 2021, Home Care Agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-1602, C.R.S. were used to increase compensation for the 2020-21 fiscal year. If there is no reimbursement rate increase, Home Care Agencies must report and attest to the Department in detail how they maintained each Direct Care Worker's compensation for the 2020-21 fiscal year.

1. Home Care Agencies must report to the Department, in the manner prescribed by the Department, by December 31 of each year.

2. The Department has ongoing discretion to request information from Home Care Agencies demonstrating how it maintained increases in compensation for Direct Care Workers beyond the reporting period.

3. Failure to provide adequate and timely reports may result in recoupment of funds.

8.507.4 AUDITING REQUIREMENTS FOR DIRECT CARE WORKERS INCREASE FOR COMPENSATION

A. Each Home Care Agency shall keep true and accurate work records to support and demonstrate use of the funds. Such records shall be retained for a period of not less than three (3) years and shall be open to inspection by the Department and are made available to be copied by the Department or its authorized representatives at any reasonable time and as often as may be necessary.

B. Home Care Agencies shall submit to the Department upon request, only records showing that the funds received for the services listed in Section 8.507.2.A. were used as a compensation for Direct Care Workers, including but not limited to:

1. Federal Employment Forms

a. W2 - Wage and Tax Statement

b. W3 - Transmittal of Wage and Tax Statement

c. 941 - Employer's Quarterly Federal Unemployment Tax Return

d. 940 - Employer's Annual Federal Unemployment Tax Return

2. State Employment Forms

a. UITR 1 – State Unemployment Insurance Tax Report

b. UITR 1A - State Unemployment Insurance Tax Report Wage List

3. Business/Corporate Tax Returns

4. Independent Contractor Forms

a. 1099's- Miscellaneous Income

b. 1096 - Annual Summary and Transmittal of U.S. Information Returns

5. Payroll Records

a. Payroll Detail

b. Payroll Summary

6. Accounting Records

a. Chart of Accounts

b. General Ledger

c. Profit & Loss Statements

d. Check Register

7. Bank Statements

8. Timesheets

9. Benefits Records

a. Health Insurance Records

b. Other Insurance Records

c. Paid Time Off Records

D. The Department may recoup part or all the funding resulting from the increase in the reimbursement rate if the Department determines that the Home Care Agency:

1. Did not use one hundred percent of any funding resulting from the rate increase to increase compensation for Direct Care Workers during fiscal year 2019-2020, as required by Section 25.5-6-1602(2), C.R.S.

2. Did not use eighty-five percent of the funding resulting from the rate increase to increase compensation for Direct Care Workers during fiscal year 2020-2021

3. Failed to track and report how it used any funds resulting from the increase in the reimbursement rate

E. If the Department makes a determination to recoup funding, the Department shall notify the Home Care Agency in writing of the Department's intention to recoup funds. The Home Care Agency has forty-five (45) days after issuance of the notice of the determination to complete any of the following actions:

1. Challenge the determination of the Department;

2. Provide additional information to the Department demonstrating compliance;

3. Submit a Plan of Correction to the Department.

F. The Home Care Agency must submit the Plan of Correction to the Department within forty-five (45) business days of the issuance of a written request from the Department. The Home Care Agency must notify the Department in writing, within five (5) business days of the receipt of the written request from the Department, if it will not be able to submit the Plan of Correction by the due date. The Home Care Agency must explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the Home Care Agency's compliance.

G. A Plan of Correction shall include, but not be limited to:

1. A detailed description of actions to be taken to resolve issues and supporting documentation demonstrating completion.

2. A detailed plan specifying the actions to be taken.

3. Employee(s) responsible for implementing the actions.

4. The implementation timeframes and date(s) for completion.

H. Upon receipt of the Plan of Correction, the Department will accept, request modifications, or reject the proposed Plan of Correction. Modifications or rejections will be accompanied by a written explanation. If a Plan of Correction is rejected, the Home Care Agency must resubmit a new Plan of Correction along with any requested documentation to the Department for review within five (5) business days of notification.

I. The Department shall notify the Home Care Agency in writing of its final determination after affording the Home Care Agency the opportunity to take the actions specified in Section 8.507.4.E. The Department shall recoup one hundred percent of the increased funding received but did not use for a direct benefit for non-administrative employee if the Home Care Agency:

1. fails to respond to a notice of determination of the Department within the time provided in Section 8.507.4.E;

2. is unable to provide documentation of compliance; or

3. the Department does not accept the Plan of Correction submitted by the service agency; or

4. Plan of Correction is not completed within the established timeframe pursuant to Section 8.507.4.I.

J. All recoveries will be conducted pursuant to Section 25.5-4-301, C.R.S. and Section 8.076.3.

8.508.103 MEDICATION ADMINISTRATION

A. If medications are administered during the course of HCBS-CHRP service delivery by the waiver service provider, the following shall apply:

1. Medications must by prescribed by a Licensed Medical Professional. Prescriptions and/or orders must be kept in the Client's record.

2. HCBS-CHRP waiver service providers must complete on-site monitoring of the administration of medications to waiver participants including inspecting medications for labeling, safe storage, completing pill counts, reviewing and reconciling the medication administration records, and interviews with staff and participants.

3. Specialized Group Facilities, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours) must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; Section 7.702.52 (C) (2021).

4. Foster Care Homes and Kinship Foster Care Homes must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; Section 708.41.J.

5. Persons administering medications shall complete a course in medication administration through an approved training entity approved by the Colorado Department of Public Health and Environment.

6. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of medication administration at § 8.609.6.D.1-8 for Clients receiving Habilitation services age eighteen (18)- twenty (20).

8.509.17 POST-ELIGIBILITY TREATMENT OF INCOME (PETI)

A. Definition

1. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the member's obligation (payment) for the payment of services.

B. Post Eligibility Treatment of Income Application

1. When a member has been determined eligible for Home and Community-based Services (HCBS) under the 300% income standard, according to Section 8.100, the Department may reduce Medicaid payment for Alternative Care Facility (ACF) services according to the procedures for calculation of PETI at Section 8.509.31.

2. PETI is required for Medicaid members residing in Alternative Care Facilities under the Home and Community Based Services (HCBS) Community Mental Health Support (CMHS) waiver.

C. Case Management Responsibilities

1. For 300% eligible members who are Alternative Care Facility (ACF) members, the case manager shall complete a State-prescribed form, which calculates the member payment according to the following procedures:

a. The member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long-Term Care (LTC) Insurance amount.

The member's Room and Board amount shall be deducted from the gross income and paid to the provider.

b. The member's Personal Needs Allowance (PNA) amount is based upon a member's gross income, up to the maximum amount set by the Department.

For a member with financial responsibility for only a spouse, the amount protected under Spousal Protection as defined in Section 8.100.7 K shall be deducted from the member's gross income.

If the member is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level amount

c. less any income of the spouse and/or dependents (excluding income from part-time employment earnings of a dependent child, as defined at Section 8.100.1, who is either a full-time student or a part-time student) shall be deducted from the member's gross income.

d. Amounts for incurred expenses for medical or remedial care for the member that are not covered by Medicare, Medicaid, or other third party shall be deducted from the member's gross income as follows:

i. Health insurance premiums, deductibles or coinsurance charges if health insurance coverage is documented.

ii. Necessary dental care not to exceed amounts equal to actual expenses incurred.

iii. Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred.

iv. Medications, with the following limitations

a) The member has a prescription for the medication.

b) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

c) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price, unless the prescriber has specifically prescribed a name brand medication over the generic formula.

e. Other necessary medical or remedial care or items shall be deducted from the member's gross income, with the following limitations:

i. The need for such care must be documented in writing by the attending physician. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

ii. Any service, supply or equipment that is available under State Plan Medicaid, with or without prior authorization, shall not be allowed as a deduction.

f. Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

If the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment, or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment, or medication is a benefit of Medicaid, the deduction shall be discontinued.

g. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the member's gross income.

h. Any remaining income shall be applied to the cost of the ACF services, as defined at Section 8.509.31.E, and shall be paid by the member directly to the provider.

i. If there is still income remaining after the entire cost of ACF services are paid from the member's income, the remaining income shall be kept by the member and may be used at the member's discretion.

2. Case managers shall inform HCBS ACF services members of their payment obligations in a manner prescribed by the Department at the beginning of each support plan year and whenever there is a significant change to their payment obligation.

a. Significant change is defined as fifty dollars ($50) or more.

3. Copies of member payment forms shall be kept in the member files at the case management agency. A copy of the form may be requested by the Department for monitoring purposes.

8.509.50 MENTAL HEALTH TRANSITIONAL LIVING HOMES

A. Definitions

1. Activities of daily living (ADLs) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and supervision to support behavior, medical needs and memory/cognition.

2. Authorized Representative means an individual designated by a member, or by the parent or guardian of the member receiving services, if appropriate, to assist the member receiving services in

acquiring or utilizing services and supports. This does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) or In-Home Support Services (IHSS).

3. Case Management Agency means a public, private, or non-governmental non-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to section 25.5-10-209.5 C.R.S. and that has signed a provider participation agreement with the state department.

4. Department means the Department of Health Care Policy and Financing, the Single State Medicaid Agency.

5. Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; or it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to, injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

6. Medication Administration as described in 25-1.5-301, C.R.S., means assisting a member with taking medications while using standard healthcare precautions, according to the legibly written or printed order of an attending physician or other authorized practitioner. Medication administration may include assistance with ingestion, application, inhalation, and rectal or vaginal insertion of medication, including prescription drugs. "Administration" does not include judgment, evaluation, assessment, or the injections of medication, the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by the member.

7. Mental Health Transitional Living Home (MHTL) Certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to the Department after the provider has met all licensing and regulatory requirements.

8. Protective Oversight means monitoring and guidance of a member to assure their health, safety, and well-being. Protective oversight includes but is not limited to: monitoring the member while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the member to carry out activities of daily living, and facilitating medical and other health appointments.

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

10. Provider means the entity that is enrolled with the Department and holds the Assisted Living Residence license and MHTL certification.

B. Member Eligibility

1. MHTL services are available to members who meet the following requirements:

a. Members are enrolled in the HCBS-CMHS waiver; and

b. Members require the specialized services provided under the MHTL as determined by assessed need.

C. Member Benefits

1. The MHTL service will assist the member to reside in the most integrated setting appropriate to their needs. Staff will be specifically trained to support members with a severe and persistent mental illness and who may be experiencing a mental health crisis or episode.

2. This residential service will include the following:

a. Protective oversight and supervision;

b. Assistance with administering medication and medication management;

c. Assistance with community participation and support in accessing the community;

d. Assistance with recreational and social activities;

e. Housing planning and navigation services as appropriate for members experiencing homelessness/at risk for homelessness;

f. Life skills training; and

g. ADL support as needed.

3. Room and board is not a benefit of MHTL services. Members are responsible for room and board in an amount not to exceed the Department's established rate.

4. Additional services that are available as a State Plan benefit or other HCBS-CMHS waiver service are not a MHTL benefit.

5. Member engagement opportunities shall be provided by the MHTL home, as outlined in 6 CCR 1011-1, Chapter VII, Section 12.19-26.

D. Member Rights

1. Members shall be informed of their rights, according to 6 CCR 1011-1, Chapter VII, Section 13 and 10 CCR 2505-10 8.484. Any modification of those rights shall be in accordance with Section 8.484.5. Pursuant to 6 CCR 1011-1, Chapter VII, Section 13.1, the policy on resident rights shall be in a visible location so that they are always available to members and visitors.

2. Members shall be informed of all policies specific to the MHTL setting upon admission to the setting, and when changes to policies are made, rules and/or policies shall apply consistently to the administrator, staff, volunteers, and members residing in the facility and their family or friends who visit. Member acknowledgement of rules and policies must be documented in the support plan or a resident agreement.

3. If requested by the member, the MHTL home shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal possessions.

E. Provider Eligibility

1. To be certified as an MHTL provider, the entity seeking certification must be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. VII.

2. Applicants for MHTL Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by the Colorado Division of Fire Prevention and Control (DFPC).

3. MHTL providers must receive a recommendation for MHTL Certification. CDPHE issues a recommendation for MHTL Certification to the Department when the provider is in full compliance with the requirements set forth in these regulations.

4. No recommendation for MHTL Certification shall be issued if the owner, applicant, or administrator of the MHTL has been convicted of a felony or misdemeanor involving a crime of moral turpitude or that involves conduct that the Department determines could pose a risk to the health, safety, or welfare of the members residing in the MHTL setting.

5. All MHTL homes are operated or contracted by the Department of Human Services or Behavioral Health Administration.

F. Provider Roles and Responsibilities

1. Service Requirements

a. The facility shall provide Protective Oversight and MHTL services to members every day of the year, 24 hours per day.

b. MHTL providers shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 CCR 1011-1, Chapter VII and XXIV, Medication Administration Regulations.

c. MHTL providers shall not discontinue services to a member unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services in accordance with 6 CCR 1011-1, Ch. VII Section 11.

d. Providers shall maintain the following records/files:

i. Personnel files for all staff and volunteers shall include:

1) Name, home address, phone number and date of hire.

2) Job description, chain of supervision and performance evaluation(s).

3) Trainings completed by the staff member and date of completion.

ii. Member files shall be kept confidential and shall include:

1) The member's intake assessment, support plan and signed resident agreement.

2) Providers must document and keep a record of each medication administered, including the time and the amount taken.

e. The provider shall encourage and assist members' participation in engagement opportunities and activities within the MHTL home community and the wider community, when appropriate.

f. The provider shall develop emergency policies that address, at a minimum, a plan that ensures the availability of, or access to, emergency power for essential functions and all member-required medical devices or auxiliary aids.

2. Person Centered Support Plan

a. The support plan must outline the goals, choices, preferences, and needs of the member. Medical information must also be included, specifically:

i. If the member is taking any medications and how they are administered, with reference to the Medication Administration Record (MAR);

ii. Supports needed with ADLs;

iii. Special dietary needs, if any; and

iv. Reference to any documented physician orders.

b. The support plan must contain evidence that the member and/or their guardian, designated representative, or legal representative has had the opportunity to participate in the development of the support plan, has reviewed it, and has signed in agreement with the plan.

3. Incident Reporting

a. An Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a member. An incident may endanger or negatively impact the mental and/or physical well-being of a member.

b. Case management agencies and providers shall have a written policy and procedure for the timely reporting, recording and reviewing of incidents which shall include, but not be limited to:

i. Death of member receiving services;

ii. Hospitalization of member receiving services;

iii. Medical emergencies, above and beyond first aid, involving member receiving services;

iv. Allegations of abuse, neglect, exploitation, or mistreatment;

v. Injury to member or illness of member;

vi. Damage or theft of member's personal property;

vii. Errors in medication administration;

viii. Lost or missing person receiving services;

ix. Criminal activity;

x. Incidents or reports of actions by member receiving services that are unusual and require review; and

xi. Use of a rights modification.

c. A provider must submit a verbal or written report of every incident to the HCBS member's Case Management Agency (CMA) case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

i. Name of person reporting;

ii. Name of member who was involved in the incident;

iii. Member's Medicaid identification number;

iv. Name of persons involved or witnessing the incident;

v. Incident type;

vi. Date, time, and duration of incident;

vii. Location of incident;

viii. Persons involved;

ix. Description of incident;

x. Description of action taken;

xi. Whether the incident was observed directly or reported to the provider;

xii. Name of person notified;

xiii. Follow-up action taken or where to find documentation of further follow-up;

xiv. Name of the person responsible for follow up; and

xv. Resolution, if applicable.

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

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

c. Case management agencies and providers shall review and analyze information from incident reports to identify trends and problematic practices which may be occurring in specific services and shall take appropriate corrective action to address problematic practices identified.

4. Staffing

a. The MHTL home must have appropriate staffing levels to meet the individual acuity, needs and level of assistance required of the members in the setting.

b. In addition to the trainings outlined in 6 CCR 1011-1, Ch. VII, Section 7, staff must be trained in the following topics prior to working independently with members:

i. Mental Health First Aid.

ii. Question, Persuade, Refer (QPR).

iii. Suicide and Homicide Risk Screenings.

iv. Trauma Informed Care Methodologies and Techniques.

v. Symptom Management.

vi. Behavior Management.

vii. Motivational Interviewing.

viii. Transitional Planning.

ix. Community Reinforcement and Family Training.

G. Reimbursement

1. MHTL services are reimbursed on a per diem basis, as determined by the Department. Providers must be certified and enrolled with the Department prior to rendering services.

2. Additional Charges

a. Providers shall not bill supplemental charges to any members, except for amounts designated as copayments by the Department.

i. Federal regulations require that Medicaid providers accept Medicaid reimbursements as payment in full (42 C.F.R. § 447.15). Section 25.5-4-301(1), C.R.S., prohibits providers from charging members or their responsible parties for Medicaid services covered under Title XIX of the Social Security Act.

ii. HCBS members are not liable for the cost or additional cost of any waiver service

iii. Disallowed supplemental charges include, but are not limited to, any fees such as enrollment fees or one-time fees, annual or monthly fees, registration fees, program placement hold fees, fees for supplies, basic utilities.

8.511 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.511.1 DEFINITIONS

Definitions below only apply to Section 8.511.

A. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of Home and Community-Based Services (HCBS) required by the Colorado Department of Health Care Policy and Financing. The Department shall publish current and previous Base Wage rates and related effective dates on the Provider Rates and Fee Schedule website.

B. Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

C. Direct Care Worker means a non-administrative employee or independent contractor of a Provider Agency or Participant Directed Program Employer of Record who provides hands-on care, services, and support to older adults and individuals with disabilities across the long-term services and supports continuum within home and community-based settings.

D. Minimum Wage means the rate of pay established in accordance with Section 15 of Article XVIII of the State Constitution and any other minimum wage established by federal or local laws or regulations. In addition to state wage requirements, federal or local laws or regulations may apply minimum, overtime, or other wage requirements to some or all Colorado employers and employees. If an employee is covered by multiple minimum or overtime wage requirements, the requirement providing a higher wage, or otherwise setting a higher standard, shall apply.

E. Plan of Correction means a formal, written response from a provider agency to the Department on identified areas of non-compliance with requirements listed in Section 8.511.4.

F. Participant Directed Program means a service model that provides participants who are eligible for Home and Community-Based Services the ability to manage their own in-home care, or have care managed by an authorized representative, provided by a direct care worker. Participant Directed Program participants, or their authorized representative, operate as Employers of Record with an established FEIN.

G. Provider means any person, public or private institution, agency, or business enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods. Pursuant to this rule, a provider that renders qualifying service(s) accepts responsibility to ensure qualifying Direct Care Workers currently under their employment are paid, at a minimum, the base wage.

H. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of Home and Community-Based Services (HCBS). For purposes of this rule, the per diem wage shall apply to Direct Care Workers of residential service providers.

8.511.2 QUALIFYING SERVICES

A. When applicable, the Department will increase reimbursement rates for select services to support the base wage. Providers must use this increased funding to ensure all Direct Care Workers are paid the

base wage or higher within the timeframe established by the Department. Services requiring Direct Care Workers to be paid at least the base wage include:

1. Adult Day Services
2. Alternative Care Facility (ACF)
3. Community Connector
4. Consumer Directed Attendant Support Services (CDASS)
5. Foster Care Home (Children's Habilitation Residential Program)
6. Group Home Habilitation (CHRP)
7. Group Residential Support Services (GRSS)
8. Homemaker
9. Homemaker Enhanced
10. Host Home (CHRP)
11. In-Home Support Services (IHSS)
12. Individual Residential Support Services (IRSS)
13. Job Coaching
14. Job Development
15. Mental Health Transitional Living Homes
16. Mentorship
17. Pediatric Personal Care
18. Personal Care
19. Prevocational Services
20. Respite
21. Specialized Habilitation
22. Supported Community Connections
23. Supported Living Program

B. In the event that a Direct Care Worker, based on state or local minimum wage laws, is eligible for a minimum wage that exceeds the base wage requirement, the Provider is required to compensate at the higher wage.

C. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage by the percent of the Department's reimbursement rate increase.

D. The Department may add additional qualifying services that are applicable to this rule and not listed above.

8.511.3 PROVIDER RESPONSIBILITIES

A. The Provider must ensure that contact information on file with the Department is accurate; information shall be utilized by the Department to complete oversight responsibilities per Section 8.511.4.

B. Providers shall notify Direct Care Workers annually who are affected by the base wage requirement about Direct Care Worker rights, Direct Care Employer obligations, and the minimum state and local direct care employment standards.

C. Providers shall publish and make readily available the Department's designated contact for Direct Care Workers to submit questions, concerns or complaints regarding the base wage requirement.

D. Providers shall submit specific information for each Direct Care Worker regarding wage rates, working hours, benefits, work location, employment status, employment type, services provided, independent contractor agreements, and any other wage related information as requested by the Department. Providers shall submit the requested informationwithin the Department-specified timeframe.

E. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the applicable services received at a minimum the base wage or a per diem wage increase.

F. Records shall be retained for no less than six (6) years and shall be made available for inspection by the Department upon request. Records may include, but are not limited to:

1. Payroll summaries and details, pay stubs with details

2. Timesheets

3. Paid time off records

4. Cancelled checks (front and back)

5. Direct deposit confirmations

6. Independent contractor documents or agreements

7. Per diem wage documents

8. Accounting records such as: accounts receivable and accounts payable

8.511.4 REPORTING & AUDITING REQUIREMENTS

A. The Department has ongoing discretion to request information from providers to demonstrate that all Direct Care Workers received the wage (base or per diem) increase. All records related to the base wage requirement received by the Provider for the applicable services shall be made available to the Department upon request, within specified deadlines.

B. Providers shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department.

C. Failure to submit Direct Care Worker information as required or failure to provide adequate documents and timely responses may result in the Provider being required to submit a plan of correction and/or recoupment of funds. The Department may suspend payment of claims until requested information is received and approved by the Department.

D. If a plan of correction is requested by the Department, the Provider shall submit the plan of correction by the date specified by the Department. The Provider must notify the Department in writing within five (5) business days of receipt of the request if they will not be able to meet the deadline. The Provider must explain the rationale for the delay and the Department may or may not grant an extension in writing.

E. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider must resubmit a new plan of correction along with any requested documentation to the Department for review within five (5) business days of notification.

F. The Department may recoup part or all of the funding resulting from the base wage increase if the Department determines the Provider is not in compliance with Section 8.511.

G. If such determination is made to recoup funds, the Provider will be notified by the Department. All recoupments will be conducted pursuant to C.R.S. Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.050.6, Informal Reconsideration and Appeals of Overpayments Resulting from Review or Audit Findings.

8.515.85.O POST-ELIGIBILITY TREATMENT OF INCOME (PETI)

1. Definition

a. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the member's obligation (payment) for the payment of services.

2. Post-Eligibility Treatment of Income Application

a. When a member has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, the Department may reduce Medicaid payment for Supported Living Program services according to the procedures at Section 8.515.85.C

b. PETI is required for Medicaid members residing in Supported Living Programs under the Home and Community Based Services (HCBS) Brain Injury (BI) waiver

3. Case Management Responsibilities

a. For 300% eligible members who reside in a Supported Living Program (SLP), the case manager shall complete a State-prescribed form which calculates the member payment according to the following procedures:

i. The member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long-Term Care (LTC) Insurance amount.

ii. The member's Room and Board amount shall be deducted from the gross income and paid to the provider

iv.iii. The member's Personal Needs Allowance (PNA) amount is based upon a members gross income, up to the maximum amount set by the Department. For an individual with financial responsibility for only a spouse, the amount protected under Spousal Protection as defined in Section 8.100.7 K shall be deducted from the member's gross income.

v. If the individual is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding income from part-time employment earnings of a dependent child, as defined at Section 8.100.1, who is either a full-time student or a part-time student§) shall be deducted from the member's gross income.

iv. Amounts for incurred expenses for medical or remedial care for the member that are not covered by Medicare, Medicaid, or other third party shall be deducted from the member's gross income as follows:

a) Health insurance premiums, deductibles and co-insurance charges if health insurance coverage is documented.

b) Necessary dental care not to exceed amounts equal to actual expenses incurred.

c) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred.

d) Medications, with the following limitations:

1) The member has a prescription for the medication

2) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

3) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

4)

vii. Other necessary medical or remedial care shall be deducted from the member's gross income, with the following limitations:

a) The need for such care shall be documented in writing by the attending physician. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.

b) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

c) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

d) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

viii. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the member’s gross income.

vi. Any remaining income shall be applied to the cost of the SLP services, as described at Section 8.515.85.C, and shall be paid by the member directly to the provider.

~~x. If there is still income remaining after the entire cost of Supported Living Program services are paid from the member's income, the remaining income shall be kept by the member and may be used at the member's discretion.~~

~~b. Case managers shall inform HCBSSLP service members of their payment obligations in a manner prescribed by the Department at the beginning of each support plan year and whenever there is a significant change to their payment obligation.~~

~~i. Significant change is defined as fifty dollars ($50) or more.~~

~~c. Copies of member payment forms shall be kept in the member files at the case management agency. A copy of the form may be requested by the Department for monitoring purposes.~~

8.7000 Home and Community-Based Services

8.7001 Home and Community-Based Services Member Rights and Responsibilities

8.7001.A Definitions: Unless otherwise specified, the following definitions apply throughout Section 8.7000 et seq.

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.

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

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

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 8.75145 or 8.75278), only with respect to matters within the scope of, and in the manner authorized by, the court order or voluntary appointment or designation.

   ~~D~~d. 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, whether it covers the matter in question, and what manner of representation it authorizes (for example, only to receive information, or also to communicate the individual's decisions, to make decisions on behalf of the individual, and/or to take other actions).

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~~604.4~~.

9. Member means any person enrolled in the state medical assistance program, the children's basic health plan, HCBS waiver program, or State General Funded program.

10. 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.

11~~0~~. Other Residential Setting means a physical location that is residential and that is not owned, leased, operated, or managed by an HCBS ~~p~~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 ~~p~~Provider Agencies.

12~~1~~. 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.

13~~2~~. Plain Language means language that is understandable to the individual and in their native language, and it may include pictorial methods, if warranted.

14~~3~~. 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 P~~p~~rovider 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, ~~and~~ Supported Employment Services, and Youth Day Services (including Youth Day Services at homes owned, leased, or operated by Provider Agencies/independent Contractors) are provided.

15~~4~~. Provider-Owned or -Controlled Residential Setting means a physical location that is residential and that is owned, leased, operated, or managed by an HCBS P~~p~~rovider 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 P~~p~~rovider Agency or independent Contractor of ~~such~~ a ~~p~~Provider Agency; ~~and~~ foster care homes, Host Homes, group homes, residential child care facilities, and Qualified Residential Treatment Programs (QRTPs) in which Children's Habilitation Residential Program (CHRP) services are provided; and Mental Health Transitional Living Homes.

165. 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. ~~is a safety or emergency control procedure or would be covered by the Department's processes for rights suspensions or restrictive procedures pursuant to the version of Sections 8.600.4, 8.604.3, and 8.608.1-2 in effect on December 30, 2021.~~

176. 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.

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

~~vii. 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.~~, subject to the following transition period and Corrective Action Plan (CAP) exceptions:~~

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

~~1) Residential settings owned or leased by individuals receiving HCBS or their families (personal homes);~~

~~2) Professional provider offices and clinics;~~

~~3) Settings where children receive Community Connector services under the Children's Extensive Supports (CES) Waiver; and~~

~~4) Settings where people receive individual Supported Employment services.~~

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

~~1) At Case Management Agencies;~~

~~2) At a setting for which a Provider Transition Plan was not submitted by December 30, 2021 for any reason;~~

~~3) At a setting after the applicable deadline in the setting's Provider Transition Plan, with the deadline being (i) three months after the Provider Transition Plan was submitted unless adjusted with departmental approval and (ii) in no event after March 17, 2023, or March 17, 2024 for settings that have received departmental approval for an extension pursuant to the Corrective Action Plan; or~~

~~4) Involving compliance issues that have been verified as resolved through the Provider Transition Plan process and therefore no longer subject to transition.~~

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 ~~a~~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 ~~p~~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 ~~p~~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 ~~p~~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 ~~ii~~informed ~~Cc~~consent to, any provider-specific treatment, care, ~~or~~ 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.

viiix. 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 ~~p~~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 ~~p~~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 ~~p~~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 ~~storage areas~~ 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 ~~p~~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 ~~numerous~~ 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 ~~storage areas~~ locks. In addition to supplying a locker, the ~~p~~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 ~~p~~Provider Agency/its independent Contractor. The ~~p~~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 ~~p~~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 ~~p~~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 ~~g~~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 ~~undesired~~ 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 ~~p~~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.

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 ~~p~~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 ~~p~~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 ~~p~~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 25.5-10-101 through 241, 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 25.5-10-101 through 241, 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 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 ~~and~~ to be included in their Member Identified Team. The designation of a Long-Term Services and Supports Representative must occur with ~~ii~~informed c~~C~~consent of the person receiving services or, if applicable, their Legally Authorized Representative.

b. Such designation shall be in writing and shall specify the extent of the Long-Term Services and Supports Representative's involvement in assisting the Member in acquiring

or utilizing services or supports available pursuant to Sections 25.5-6-101 through 1905 and 25.5-10-101 through 306, C.R.S., 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

33. ~~———~~Post Eligibility Treatment of Income (PETI) means the calculation used to determine the Member's obligation (payment) for the payment of residential services.

8.7202.BB Post Eligibility of Treatment of Income (PETI)

12~~.~~ Post Eligibility Treatment of Income Application

a. When a Member has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, the Department may reduce the Medicaid payment for Alternative Care Facility and Supported Living Programs (SLP) services according to the procedures set forth in this section.

b. PETI is required for Medicaid Members residing in Alternative Care Facilities and Supported Living Programs under the Home and Community Based Services (HCBS) Elderly, Blind, and Disabled (EBD), Community Mental Health Supports (CMHS), and Brain Injury (BI) waivers.

23~~.~~ Case Management Responsibilities

a. For 300% eligible Members who reside in an Alternative Care Facility (ACF) or Supported Living Program, the Case Manager shall complete a State-prescribed form, which calculates the Member payment according to the following procedures:

i. The Member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long-Term Care (LTC) Insurance amount if the Long-Term Care Insurance (LTC) amount is applicable.

ii. The Member's Room and Board amount shall be deducted from the gross income and paid to the Provider Agency.

iii. The Member's Personal Needs Allowance (PNA) amount is based upon a Member's gross income, up to the maximum amount set by the Department.

iv. For a Member with financial responsibility for only a spouse, the amount protected under Spousal Protection as defined in Section 8.100.7 K shall be deducted from the Member's gross income.

v. If the Member is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding pan-time employment earnings of dependent children as defined at Section 8.100.1) shall be deducted from the Members gross income.

vi. Amounts for incurred expenses for medical or remedial care for the Member that are not covered by Medicare, Medicaid, or other third party, shall be deducted from the member's gross income as follows:

1) Health insurance premiums, deductibles or co-insurance charges if health insurance coverage is documented; and

2) Necessary dental care not to exceed amounts equal to actual expenses incurred; and

3) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred; and

4) Medications, with the following limitations:

a) The Member has a prescription for the medication.

b) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

c) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price, unless the prescriber has specifically prescribed a name brand medication over the generic formula.

vii. Other necessary medical or remedial care or items shall be deducted from the Member's gross income, with the following limitations:

1) The need for such care must be documented in writing by the attending physician. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

2) Any service, supply or equipment that is available under the Medicaid State Plan, with or without prior authorization, shall not be allowed as a deduction.

viii. Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

1) The Member must provide documentation, such as a receipt, for all Non-covered medical items to the Case Manager to be attached to the State-prescribed form.

ix. If the Case Manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

x. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the Member's gross income.

xi. Any remaining income shall be applied to the cost of the Alternative Care Facility (ACF), as defined at Section 8.7563 or Support Living Program (SLP) as defined at Section 8.7550 shall be paid by the Member directly to the Provider Agency.

xii. If there is still income remaining after the entire cost of Alternative Care Facility (ACF) or Supported Living Program (SLP) services is paid from the Member's income, the remaining income shall be kept by the Member and may be used at the Member's discretion.

b. Case Managers shall inform HCBS Alternative Care Facility and Supported Living Program Members of their payment obligations in a manner prescribed by the Department at the beginning of each support plan year and whenever this is a significant change to their payment obligation.

i. Significant change is defined as fifty dollars ($50) or more.

c. Copies of Member payment forms shall be kept in the Member files at the Case Management Agency. A copy of the form may be requested by the Department for monitoring purposes.

8.7400 Home and Community-Based Services Provider Agency Requirements

8.7401 Statement of Purpose and Scope

A. The purpose of this Section 8.7400 is to outline requirements for Home and Community-

Based Services (HCBS) Provider Agencies. These rules apply to all HCBS waivers.

8.7402 Definitions: Unless otherwise specified, the following definitions apply throughout Section 8.7000 et seq.

A. Case Manager is as defined in Section 8.7200.B.5.

B. Case Management Agency is as defined in Section 8.7100.A.8.

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

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

E. Department is as defined in Section 8.7200.B.14

F. Direct Care Worker means a non-administrative employee or independent Contractor of a Provider Agency or Consumer Directed Attendant Support Services employer who provides hands-on care, services, and support to older adults and individuals with disabilities across the Long-Term Services and Supports continuum within Home and Community-Based settings.

G. Discrimination is defined at Section 8.7001.A.3.

H. Guardian is as defined at Section 8.7100.A.33.

I. Health First Colorado means the state Medicaid program providing public health insurance for qualifying Coloradans.

J. Home and Community-Based Services Waivers are as defined at Section 8.7100A.35.

K. An Incident means an event or occurrence that may endanger or negatively impact the mental and/or physical well-being of a Member.

L. Intellectual and Developmental Disability is defined at Section 8.7100.A.40.

M. Legally Authorized Representative is defined at Section 8.7001.A.7.

N. Member is defined at Section ~~8.7200.B.22.~~ 8.7001.A.9.

O. Medicaid means Health First Colorado, the Colorado state Medicaid program.

P. Organized Health Care Delivery System (OHCDS) means a Case Management Agency that contracts with other qualified providers to furnish services authorized in any of the Home and Community-Based Services waivers. The OHCDS is the Medicaid provider of record for a Member whose services are delivered through the OHCDS.

Q. Prior Authorization Request (PAR) means a request submitted to either the Case Management Agency or the Department prior to rendering services for authorization to provide and bill for an item or service for a Member.

R. Protected Health Information (PHI) means individually identifiable health information, including, without limitation any information, whether oral or recorded in any form or medium that relates to the past, present or future physical or mental condition of an individual; the provision of health

care to an individual; or the past, present or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information (PHI) includes, but is not limited to, any information defined as Individually Identifiable Health Information pursuant to 42 C.F.R. § 160.103.

S. Provider Agency means an Agency which has a contract with the Department to provide one or more of the services listed within Section 8.7500, et seq.

T. 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.

U. Provider Specialty means a service that an HCBS Provider Agency may deliver and be reimbursed for upon meeting the service-specific qualifications and enrolling through the Department's Fiscal Agent.

V. Telehealth means the provision of health care remotely using telecommunications technologies to provide approved services and supports through HCBS waivers when the Member is in a different location from the provider.

8.7403 Provider Agency Certification, Decertification and Termination

A. Certification

1. For services that require HCBS Certification, Provider Agencies shall obtain Certification prior to rendering or billing for services.

2. A Provider Agency seeking HCBS Certification must submit a request to the Department or its agent.

3. Upon receipt of the request, the Department or its agent shall forward Certification information and relevant state application forms to the requesting Agency.

4. Upon receipt of the completed application from the requesting Agency, the Department or its agent shall review the information and complete an on-site review of the Agency, based on the state regulations for the service for which Certification has been requested.

5. Following completion of the on-site review, the Department or its agent shall notify the Provider Agency Applicant of its recommendation by forwarding the following information:

    a. Results of the on-site survey;

    b. Recommendation of approval, denial, or provisional approval ofCertification; and

    c. If appropriate, a Corrective Action Plan to satisfy the requirements of a provisional approval.

6. Determination of Certification approval, provisional approval, or denial shall be made by the Department after the completed application is submitted by the Agency.

B. Change in Information

1. Provider Agencies shall notify the Department of any material or substantial change in information contained in the enrollment application given to the Department by the ~~Rrovider~~Provider Agency. This notification shall be made in the Provider Portal within 35 calendar days of the event triggering the reporting obligation. A material or substantial change includes a change in ownership; disclosures; licensure; federal tax identification number, bankruptcy; address, telephone number, or email address; criminal convictions related to involvement in any Medicare, Medicaid or Social Security Act, Title XX Health Services Block Grant program; or change in Geographic Service Area.

2. Pursuant to Section 8.130.45, Provider Agencies shall notify the Department within 35 calendar days of the loss or termination of Certification and/or licensure that is required for Home and Community-Based Services provider enrollment. The notification shall be submitted through the Provider Portal as a maintenance application to terminate the Provider Agency's enrollment of a specialty or as a Medicaid provider.

C. Decertification

1. The Department may decertify a Provider Agency if any of the following occur:

   a. The Provider Agency fails to comply with any federal or state statute, rules, or guidance.

   b. The Provider Agency fails to comply with any lawful requests by the Department or its agents.

   c. The Provider Agency is no longer eligible to provide the services for which the provider has received Certification.

   d. The Provider Agency poses a threat to the health, safety, or welfare of Medicaid Members.

2. Decertification may occur without prior notice if the decertification is imperatively necessary for the preservation of the public health, safety or welfare and observance of this notice requirement would be contrary to the public interest. For any decertification action taken without prior notice, the Department shall issue a written notice of decertification within five business days of the action.

3. If the Provider Agency elects to dispute the decertification, the Department must receive the Provider Agency's written request to dispute the decertification within thirty (30) calendar days of the date of the decertification notice or the dispute will not be considered.

4. The Department's determination on the decertification dispute shall include a statement of the Provider Agency's appeal rights set forth in Section 8.050.

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

8.7404 Change of Ownership

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

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

1. The new owner shall meet licensing, Certification, and approval process standards prior to enrollment.

8.7405 Documentation

A. In addition to the documentation required by 8.130.2, HCBS Provider Agency documentation shall also include the information below in the following categories:

1. Incremental units of service

a. Location of service provided;

b. Time and date service was provided, including beginning and end time;

c. Name of individual rendering service;

d. Service(s) rendered, and the exact nature of the specific tasks performed that align with the service definition(s) in 8.7500.

e. Documentation of any changes in the Member's condition or needs and action taken because of the changes; and

f. Units of service provided.

2. Per-diem units of services

a. Medication Administration Record (MAR) if applicable;

b. Daily attendance tracker; and

c. Notes, which shall include:

i. Activities Member participated in;

ii. Respite services or overnight stays elsewhere if applicable.

8.7406 Insurance Requirements

A. Provider Agencies shall maintain liability insurance in an amount sufficient to cover total bodily injury or property damage liability arising from a single incident.

B. Provider Agencies managing personal needs funds shall comply with all licensing and bonding requirements.

C. Provider Agencies rendering reimbursable Non-Medical Transportation (NMT) services shall maintain liability insurance with the following automobile liability minimum limits:

1. Bodily injury (BI) $300/$600K per person/per accident; and

2. Property damage $50,000, or

3. $500,000 combined single limit

D. Drivers who utilize their personal vehicle on behalf of a Provider Agency to provide reimbursable NMT shall maintain the following minimum automobile insurance coverage, in addition to the insurance maintained by the Provider Agency:

1. Bodily injury (BI) $25/$50K per person/per accident; and

2. Property damage $15,000.

8.7407 HCBS Provider Agency Billing

A. Claims for HCBS services are payable only if submitted in accordance with the following procedures:

1. Provider Agencies shall verify Member eligibility prior to delivering services;

2. Provider Agencies shall verify a Prior Authorization Request (PAR) has been approved for the services in question, prior to service provision and claim submission;

3. Claims shall be submitted to the Fiscal Agent in accordance with Department billing manuals and policies, outlined in Section 8.043;

4. Claims shall only be submitted for services the Provider Agency is enrolled to provide, including correct HCBS specialties;

5. Claims shall only be submitted for services provided in accordance with all applicable federal and state statutes, regulations, and other authorities;

6. Submitted claims shall include all data elements required to complete the National Uniform Claim Committee Form 1500 (CMS 1500).

B. Payment shall not exceed rate shown in the Health First Colorado Fee Schedule in effect on the date services are provided.

C. Pursuant to § 25.5-4-301, C.R.S., Provider Agencies shall not collect copayments or seek reimbursement from eligible Members for covered services.

~~C.~~D. Pursuant to 10 CCR 2505-8.076, Provider Agency claims for reimbursement shall be subject to review by the Department or its agent. This review may be completed before or after payment has been made to the ~~p~~Provider Agency. When the review identifies areas of noncompliance, the ~~p~~Provider Agency may~~shall~~ be required to submit a plan of correction that is monitored for completion by the Department or its agent. When the ~~p~~Provider Agency has received reimbursement for services and the review by the Department or its agent identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will ~~P Agency~~subject to overpayment recovery and/or suspected fraud referral to law enforcement, and the provider may be subject to~~,~~ prepayment review and/or~~,~~ termination of its provider

participation agreement. ~~, and/or suspected fraud referral to law enforcement.~~

8.7408 Policies and Procedures

A. Provider Agencies shall establish and maintain policies and procedures for each of the items below.

1. Staffing and employment

a. Provider Agencies shall have written policies and procedures for recruiting, selecting, orienting, training, and terminating employees and Contractors. Such policies shall include procedures for conducting criminal background checks, a Colorado Adult Protection Services (CAPS) check, and reference checks prior to employing staff or Contractors providing supports and services, and mitigation procedures to be used if the Provider Agency becomes aware of information that indicates a staff Member or volunteer could pose a risk to the health, safety, and welfare of the Members served.

b. Provider Agencies shall have written policies and procedures to establish qualifications for employees and Contractors. Such policies shall include:

i. Responsibilities assigned to each job description for employees.

ii. Procedures for initial and continuing training of staff to ensure all duties and responsibilities are accomplished in a competent manner.

iii. Supervision and management of staff and oversight of contractors.

iv. Restrictions prohibiting staff on-site access if they are under the influence of alcohol or illicit drugs.

2. Medication Administration

a. Provider Agencies shall establish and maintain policies and procedures for the administration of medication including administration by gastrostomy as part of gastrostomy services described at Section 8.7416

b. Provider Agencies shall establish and maintain written policies and procedures for the appropriate procurement, storage, distribution, and disposal of medications.

i. All medications shall be stored under proper conditions of temperature and light, and with regard for safety.

ii. Discontinued and outdated medications, and medication containers with worn, illegible, or missing labels shall be promptly disposed of in a safe manner.

iii. A record shall be maintained of missing, destroyed, or contaminated medications.

c. Medication reminder boxes shall be used in accordance with Section 25-1.5-303(1), C.R.S.

3. Protected Health Information (PHI)

a. Provider Agencies shall have written policies governing access to duplication and dissemination of information from the Member's records in accordance with Section 26-1-114(3), C.R.S. and 42 C.F.R. § 164.502. Within the Agency policies for protection of confidentiality, Provider Agencies shall have written policies and procedures for confidential access to Member information by employees as needed to provide the assigned services.

4. Mistreatment, Abuse, Neglect, and Exploitation (MANE)

a. Pursuant to Section 25.5-10-221, C.R.S., Provider Agencies shall prohibit MANE of any Member.

b. Provider Agencies shall have written policies and procedures for thoroughly investigating cases of alleged or suspected MANE of any Member.

c. MANE policies and procedures shall be consistent with state law and provide a mechanism for monitoring to detect instances of MANE. Monitoring is to include, at a minimum, the review of:

i. Incident reports;

ii. Verbal and written reports of unusual or dramatic changes in behavior(s) of Members; and,

iii. Verbal and written reports from Members, advocates, families, Guardians, and friends of Members.

d. Provider Agencies shall establish and maintain procedures for identifying, reporting, reviewing, and investigating all allegations of MANE. Documentation of all investigations shall be maintained. Documentation shall include:

i. The Incident report and preliminary results of the investigation;

ii. A summary of the investigative procedures utilized;

iii. The full investigative finding(s); and

iv. The actions taken.

e. Provider Agencies shall

i. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and Contractors who have engaged in MANE.

ii. Ensure that employees and Contractors are made aware of applicable state law and Agency policies and procedures related to MANE.

iii. Require immediate reporting when observed by employees and Contractors according to Agency policy and procedures and to the Agency administrator or his/her designee;

f. Require reporting of allegations within 24 hours to a Legally Authorized Representative and Case Management Agency.

5. Protection of individual rights

   a. All Provider Agencies shall have written policies and procedures concerning the exercise and protection of individual rights pursuant to Sections 25.5-10-218 through 231, C.R.S. and Section 8.7001.

   b. Provider Agencies shall supply Members with a Plain Language explanation of their rights.

6. Non-discrimination policies

   a. Provider Agencies shall have policies in place that prohibit Discrimination on the basis of race, religious or political affiliation, gender, national origin, age, or disability and outline the Agency's follow up procedures to address any discriminatory acts.

7. Dispute resolution

   a. Provider Agencies shall have procedures for resolution of disputes involving Members:

      i. Who were found not eligible or no longer eligible to receive the service(s) from the Provider Agency;

      ii. Whose services or supports are to be terminated; or,

      iii. Whose services set forth in the Person-Centered Support Plan are to be changed, reduced, or denied.

   b. The procedure shall contain an explanation of the process to be used by Members, prospective Members, or Legally Authorized Representatives if they are dissatisfied with the decision or action of the Provider Agency.

   c. The dispute resolution procedures of the Provider Agency shall, at a minimum, provide the parties the opportunity to present information and evidence in support of their positions to an impartial decision maker. The impartial decision maker may be the director of the Agency taking the action or their designee. The impartial decision maker shall not have been directly involved in the specific decision at issue.

   d. Provider Agencies shall supply Members with a Plain Language explanation of available dispute resolution procedures, along with outside Agency contact information, including phone numbers, for assistance.

   e. Provider Agencies must provide Members with 15 days notice of any change to services, including termination.

8. Grievances and Complaints

   a. Provider Agencies shall have procedures setting forth a process for the timely resolution of Grievances or Complaints of Members, prospective Members, or Legally Authorized Representatives, as appropriate. Use of the Grievance/Complaint procedure shall not prejudice the future provision of appropriate services or supports. No individual shall be coerced, intimidated,

threatened, or retaliated against because the individual has exercised his or her right to file a Grievance/Complaint or participate in the Grievance process.

b. The Grievance/Complaint procedure shall, at a minimum, include:

i. Identification of the staff Member responsible to receive Grievances/Complaints;

ii. A mechanism to receive Grievances/Complaints verbally and/or in writing that requires staff receiving a verbal Grievance/Complaint to record any verbal Grievances and/or Complaints;

iii. Identification of a support person(s) to assist a Member to submit a Grievance/Complaint;

iv. An opportunity for individuals to meet and attempt to reach a mutually acceptable solution;

v. Timelines for the resolution of the Grievance/Complaint;

vi. Consideration by the Agency director or designee if the Grievance/Complaint cannot be resolved at a lower level; and,

c. Provider Agencies shall supply Members with a Plain Language explanation of available Grievance/Complaint procedures, along with outside Agency contact information, including phone numbers, for assistance.

d. Provider Agencies shall allow Grievances/Complaints to be submitted anonymously.

9. Independent Contractors

a. Provider Agencies may utilize the services of independent Contractors at their discretion. If an Agency does utilize independent Contractors, it shall conduct the vetting, training, and monitoring of, and take corrective action against Contractors.

b. Nothing in these regulations shall create any contractual relationship between any independent Contractor of the Provider Agency and the Department.

10. Contingency planning

a. Provider Agency shall have a documented contingency plan for providing services if a Member's caregiver or direct service provider are unavailable due to an emergency or unforeseen circumstances.

11. Telehealth

a. Provider Agencies that provide HCBS Telehealth services shall establish and maintain documented policies on the use of Telehealth services that comply with Section 8.756259.

12. Written Plans to Address Emergencies

a. Each HCBS Provider Agency shall have written policies and procedures to address emergencies, unless otherwise specified within service regulations.

i. Plans should include how the agency prepares for loss of staff, various emergencies, etc.

ii. Day Habilitation services shall have written plans to address emergencies regardless of service location or type of program.

8.7409 Personnel

A. Employee and Contractor records

1. The Provider Agency shall maintain records documenting the qualifications and training of employees and contractors who provide services to Members.

2. Provider Agencies shall maintain a personnel record for each employee or Contractor. The record shall contain:

a. Documentation of qualifications.

b. Documentation of trainings completed.

c. Documentation of supervision and performance evaluation or contractor management and oversight.

d. Documentation that the employee/Contractor was informed of all policies and procedures required by Section 8.7409.

e. Documentation of the job description or signed contract.

f. Documentation of a criminal background check and a CAPs check.

B. License/Certification

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

C. Medication administration

1. All employees and Contractors, not otherwise authorized by law to administer medication, who assist and/or monitor Members in the administration of medications or the filling of medication reminder boxes shall have passed a “Qualified medication administration person” or “QMAP” competency evaluation offered by an approved training entity, and shall be listed on the Department’s list of persons who have passed the requisite competency evaluation as defined in 6 CCR 1011-1, Chapter 24. Each facility shall ensure the qualifications of the QMAP employee or Contractor per 6 CCR 1011-1, Chapter 24, Section 3.

D. Trainings

1. Provider Agencies shall have an organized program of orientation and training of sufficient scope for employees and Contractors to carry out their duties and responsibilities efficiently, effectively, and competently. Training shall be provided prior to employees or Contractors having unsupervised contact with Members. The training program shall, at a minimum, provide for and include:

    a. Training related to person-centered practices, the role of the Person-Centered Support Plan, and the concept of dignity of risk;

    b. Training related to health, safety, and services and supports to be provided related to the specific needs and diagnoses of Members served;

    c. Training specific to the individual(s) for whom the employees or Contractors will be providing services and supports which includes medical or behavioral protocols, supervision, dietary and Activities of Daily Living (ADL) needs; and

    d. Provider Agencies' internal policies and procedures.

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

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

2. Provider Agencies shall comply with the CAPS check requirements set forth at §26-3.1-111(6)(a), C.R.S. and 12 CCR 2518-1, § 30.960.G-J. The Provider Agency shall maintain accurate records and make records available to the Department upon request.

    a. HCPF or its designee shall act as the oversight Provider Agency described at 26- 3.1-111(6)(a)(III) and shall receive CAPS check results for Provider Agencies requiring Certification, the prospective Agency shall:

        i. Submit to the CDPHE a copy of the CAPS check results as part of their initial application for Certification.

            1) Substantiated findings as outlined in Section 8.7409 E.2.b may result in the denial of the Medicaid enrollment application.

    b. Direct Care Workers with any of the following are prohibited from providing direct care to any Member:

        i. An allegation of MANE or harmful act, as defined in Section 26-3.1-101, C.R.S., substantiated by Adult Protection Services (APS) within the last 10 years, at a severity level of "Moderate" or "Severe" as defined in 12 CCR 2518-1; Section 30.100;

        ii. Three or more allegations of MANE or harmful act, as defined in Section 26-3.1-101, C.R.S., substantiated by APS within the last five years, at the minor severity level as defined in 12 CCR 2518; Section 30.100; or

iii. A criminal conviction of MANE against an at-risk adult defined at 26-3.1- 101, C.R.S.

iv. Only substantiated allegations for which the state level appeal process as defined as 12 CCR 2518-1; Section 30.920 has concluded shall be included in the above exclusions list.

F. Screening for Excluded Employees and Contractors

3.1. Provider Agencies shall screen for excluded employees and contractors with the US Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities (www.oig.hhs.gov) as outlined in Section 8.130.35.

8.7410 Rendering ~~s~~Services ~~a~~According to ~~the~~A Person-Centered S~~ervice~~upport ~~Plan~~ Plan

A. Provider Agencies shall develop and maintain on file copies of ~~the~~ a current person-centered ~~Person-Centered Support Plan~~service plan for all Members they serve that outlines the following:

1. The needs of the Member;

2. Services and supports that will be provided to meet the need of the Member; ~~s~~;

3. How those services and supports will be provided to the Member; and

4. All necessary information to successfully provide the agreed upon service and supports.

B. The service plan shall assure the protection of the rights of Members as defined by the Department under applicable programs, including but not limited to Section 8.7001.

C~~.~~. Members receiving services shall be included, in addition to their LTSS Representative, family members, or individuals from public and private agencies to the extent such partnership is requested by the member, in developing the service plan and have the freedom to choose from willing Provider Agencies.

D. Provider Agencies shall follow specific service plan regulations for each covered benefit they render to a Member as outlined throughout Section 8.7500. Service plans vary by name depending on the covered benefit.

E. The Provider Agency person-centered service plan shall be reviewed periodically, as needed, to determine the results achieved, if the needs of the Member are accurately reflected in the service plan, whether the services and supports identified in the service plan are appropriate to meet the Member's needs as assessed in the Person-Centered Support Plan, and what actions are necessary for the service plan to be successfully implemented.

F. Staff providing direct care to Members shall have access to or a copy of the ~~Person-Centered Support Plan~~service plan and shall render services as required in the ~~Person-Centered Support Plan~~service plan.

G. Provider Agencies shall render services according to the agreed upon service plan and Person-Centered Support Plan (PCSP). ~~and~~ Provider Agencies shall coordinate with other Provider

Agencies, when applicable. ~~Members receiving services shall be included in developing the Person-Centered Support Plan and have the freedom to choose a willing Provider Agency.~~

H. A Provider Agency shall not condition a Member's receipt of any service on the Member's agreement to receive other services from the ~~p~~Provider Agency.

I. A Provider Agency shall not discontinue or refuse to provide agreed upon services to a Member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.7411 Incident Reporting

A. Provider Agencies shall complete the timely reporting, recording, and reviewing of Incidents which shall include, but not be limited to:

1. Death of Member receiving services;
2. Hospitalization of Member receiving services;
3. Medical emergencies~~,~~ above and beyond first aid~~, involving Member receiving services~~;
4. Allegations of MANE;
5. Injury to Member or illness of Member;
6. Damage or theft of Member's personal property;
7. Errors in medication administration;
8. Lost or missing person receiving services;
9. Criminal activity; and
10. Incidents or reports of actions by Member receiving services that are unusual and require review.

B. A Provider Agency must submit a verbal or written report for all Critical Incidents, as defined at Section 8.7201.L.5, to the HCBS Member's Case Management Agency Case Manager within 24 hours of discovery of the actual or alleged Incident. All other incidents must be reported to the Case Manager within two business days. The report must include:

1. Name of person reporting;
2. Name of Member who was involved in the Incident;
3. Member's Medicaid identification number;
4. Name of persons involved or witnessing the Incident;
5. Incident type;
6. Date, time, and duration of Incident;
7. Location of Incident;

8. Persons involved;

9. Description of Incident;

10. Description of action taken;

11. Whether the Incident was observed directly or reported to the Provider Agency;

12. Name of person notified;

13. Follow-up action taken or where to find documentation of further follow-up;

14. Name of the person responsible for follow up; and

15. Resolution, if applicable.

C. If any of the above information is not available and reported to the Case Management Agency Case Manager within 24 hours of the Incident, the Provider Agency must submit follow up information as soon as it is obtained.

D. Additional follow up information may also be requested by the Case Manager, or the Department. A Provider Agency is required to submit all follow up information within the timeframe specified by the Case Management Agency.

E. Provider Agencies shall review and analyze information from Incident reports to identify trends and problematic practices which may be occurring in specific services and shall take appropriate corrective action to address problematic practices identified.

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

8.7412 Environmental Standards for Provider-Owned or -Controlled Settings

A. Provider Agencies shall ensure that Provider-Owned or -Controlled Settings defined at Sections 8.7001.A.1~~43~~ and .1~~54~~ shall comply with all the environmental standards outlined below, in addition to the requirements set forth in Section 8.7001.B

1. The Provider Agency shall conduct fire drills at least quarterly at each physical facility.

2. All physical facilities shall have working smoke detectors installed and fire extinguishers that have not expired in easily accessible locations that comply with 8 C.C.R. § 1507- 101:3.

3. All physical facilities shall have first aid supplies available.

4. All Provider Agencies shall comply with the Americans with Disabilities Act (ADA) requirements for accessibility of physical facilities.

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

8.7413 Room and Board

A. Effective January 1 of each year, the Department shall establish a uniform room and board payment for all Medicaid Members receiving residential HCBS in or through:

1. Alternative Care Facility

2. Supportive Living Program

3. Transitional Living Program

4. Individual Residential Service and Supports

5. Group Residential Services and Supports

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

7. Mental Health Transitional Living Homes

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

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

8.7414 Medication Administration

A. Provider Agencies shall provide sufficient support to Members in the use of prescription and non- prescription medications. Members shall be presumed capable of self-administration unless they are determined otherwise. The type and level of medication administration support provided shall be determined by the results of an assessment performed by a qualified person. Medications shall be administered only by persons authorized in accordance with 6 CCR 1011-1, Chapter VII and XXIV.

1. No prescription medication shall be administered without a written order by a medically licensed provider. Medications/prescriptions shall be reviewed by a licensed medical professional annually, or more frequently if recommended by the licensed medical professional or required by law.

2. The Provider Agency shall ensure that a Member's refusal to take medication(s) and/or any adverse reaction to a medication are recorded in the Member's medication administration record and reported to the Member's licensed medical provider.

3. For Members receiving assistance with medication administration, the licensed medical provider's order shall be maintained in the Member's record.

4. Qualified medication administration personnel shall record all medications administered, including the date, time and amount of each medication administered.

B. For Members who are independent in the administration of medications and who do not require monitoring each time medication is taken, the Provider Agency shall review of medications quarterly to determine that medications are taken correctly.

C. CHRP **Medication Administration**

1. If medications are administered during the course of HCBS-CHRP service delivery by the waiver service provider, the following shall apply:

   a. Medications must be prescribed by a Licensed Medical Professional. Prescriptions and/or orders must be kept in the Member's record.

   b. HCBS-CHRP waiver service providers must complete on-site monitoring of the administration of medications to waiver participants including inspecting medications for labeling, safe storage, completing pill counts, reviewing, and reconciling the medication administration records, and interviews with staff and participants.

   c. Specialized Group Facilities, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours) must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; Section 7.702.52 (C) (2021).

   d. Foster Care Homes and Kinship Foster Care Homes must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; Section 708.41.J.

   e. Persons administering medications shall complete a course in medication administration through an approved training entity approved by the Colorado Department of Public Health and Environment.

   f. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of medication administration at § 8.609.6.D.1-8 for Members receiving Habilitation services age eighteen (18)-twenty (20).

8.7415 Psychotropic Medications

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

   1. When prescribed by a ~~physician~~ licensed medical professional following a psychiatric evaluation; and

   2. After Informed Consent of the Member or Legally Authorized Representative has been obtained.

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

   1. Be as directed in a time-limited prescription of no more than 90 days written by an authorized medical professional and reviewed at least annually by medically licensed provider;

   2. Be administered per prescriber's orders;

3. Include regular monitoring of the Member for side effects;

4. Include documentation of the effects of medications and any changes in medication;

5. Not be ordered on a PRN or “as needed” basis; and

6. Be reviewed by the Human Rights Committee, if the Member is enrolled in a waiver in which the committee is applicable.

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

8.7416 Gastrostomy Services for Developmental Disabilities (DD) and Supported Living Services (SLS) Waivers

A. Gastrostomy services means assistance with the ingestion of food or administration of medication through gastrostomy tubes.

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

C. Gastrostomy services shall not be administered by an unlicensed individual unless that individual is trained and supervised by a licensed physician, nurse, or other practitioner. The licensed nurse, physician or other practitioner overseeing the initial and periodic training shall document in the employee or contractor record:

1. The date or dates on which the training occurred;

2. Documentation confirming that, in the opinion of such licensed nurse, physician, or other practitioner, the unlicensed individual has reached proficiency in performing all aspects of the individualized protocol referred to in section 8.7416.E.1; and,

3. The legible signature and title of such licensed nurse, physician, or other practitioner.

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

1. The supervising nurse, physician or other authorized health care practitioner shall document each instance of monitoring of the Member.

E. The Provider Agency shall ensure that a physician, licensed nurse, or other practitioner has developed a written, individualized gastrostomy service protocol for each Member requiring such service, and that the protocol is updated each time the orders change for that Member’s gastrostomy services.

1. The Provider Agency shall maintain the individualized protocol in the record of the Member. The protocol shall include, at a minimum:

a. The proper procedures for preparing, storing, and administering gastrostomy services;

b. The proper care and maintenance of the gastrostomy site, needed materials

and equipment;

c. The identification of possible problems associated with gastrostomy services; and,

d. A list of health professionals to contact in case of problems, including the physician of the individual receiving gastrostomy services and the licensed nurse(s) and/or physician(s) who are responsible for monitoring the unlicensed person(s) performing gastrostomy services pursuant to section 8.7416.

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

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

H. For each gastrostomy service received by a Member, the Provider Agency shall ensure the following documentation is included in the Member's record:

1. A written record of each nutrient and fluid administered;

2. The beginning and ending time of nutrient or fluid intake;

3. The amount of nutrient or fluid intake;

4. The condition of the skin surrounding the gastrostomy site;

5. Any problem(s) encountered and action(s) taken; and

6. The date and signature of the person performing the procedure.

8.7417 Telehealth

A. Provider Agencies that choose to use HCBS Telehealth shall comply with all regulations at Section 8.7562~~59~~.

8.7418 Base Wage Requirement for Direct Care Workers

A. Base Wage Requirement for Direct Care Workers Definitions

Definitions below only apply to Section 8.7418.

1. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of Home and Community-Based Services (HCBS) required by the Colorado Department of Health Care Policy and Financing. The Department shall publish current and previous Base Wage rates and related effective dates on the Provider Rates and Fee Schedule website.

2. Direct Care Worker is as defined in 10 CCR 2505-10-8.7402.F.

3. Direct Benefit means compensation that is directly bestowed conferred onto Direct Care Workers for their sole benefit and does not include direct benefits to the provider which may have an indirect benefit to the Direct Care Workers.

4. Minimum Wage means the rate of pay established in accordance with Section 15 of Article XVIII of the State Constitution and any other minimum wage established by federal or local laws or regulations. In addition to state wage requirements, federal or local laws or regulations may apply minimum, overtime, or other wage requirements to some or all Colorado employers and employees. If an employee is covered by multiple minimum or overtime wage requirements, the requirement providing a higher wage, or otherwise setting a higher standard, shall apply.

5. Plan of Correction means a formal, written response from a Provider Agency to the Department on identified areas of non-compliance with requirements listed in Section 8.511.4.

6. Participant Directed Program means a service model that provides participants who are eligible for Home and Community-Based Services the ability to manage their own in-home care, or have care managed by an authorized representative, provided by a direct care worker. Participant Directed Program participants, or their authorized representative, operate as Employers of Record with an established FEIN.

7. Provider means any person, public or private institution, agency, or business enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods. Pursuant to this rule, a provider that renders qualifying service(s) accepts responsibility to ensure qualifying Direct Care Workers currently under their employment are paid, at a minimum, the base wage.

8. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of Home and Community-Based Services (HCBS).

B. Qualifying Services for Base Wage Requirement for Direct Care Workers

1. When applicable, the Department will increase reimbursement rates for select services to support the base wage. Providers must use this increased funding to ensure all Direct Care Workers are paid the wage required by the Department or higher within the timeframe established by the Department. Services requiring Direct Care Workers to be paid at least the base wage include:

a. Adult Day Services

b. Alternative Care Facility (ACF)

c. Community Connector

d. Consumer Directed Attendant Support Services (CDASS)

e. Foster Care Home (Children's Habilitation Residential Program)

f. Group Home Habilitation (CHRP)

g. Group Residential Support Services (GRSS)

h. Homemaker

i. Homemaker Enhanced

j. Host Home (CHRP)

k. In-Home Support Services (IHSS)

l. Individual Residential Support Services (IRSS)

m. Job Coaching

n. Job Development

o. Mental Health Transitional Living Homes

p. Mentorship

q. Pediatric Personal Care

r. Personal Care

s. Prevocational Services

t. Respite

u. Specialized Habilitation

v. Supported Community Connections

w. Supported Living Program

x. Workplace Assistance

2. In the event that a Direct Care Worker, based on state or local minimum wage laws, is eligible for a minimum wage that exceeds the base wage requirement, the Provider is required to compensate at the higher wage.

3. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage by the percent of the Department's reimbursement rate increase.

4. The Department may add additional qualifying services that are applicable to this rule and not listed above.

C. Base Wage Provider Responsibilities

1. The Provider must ensure that contact information on file with the Department is accurate; information shall be utilized by the Department to complete oversight responsibilities per Section 8.7418.D.

2. Providers shall notify Direct Care Workers annually who are affected by the base wage requirement about Direct Care Worker rights, Direct Care Employer obligations, and the minimum state and local direct care employment standards.

3. Providers shall publish and make readily available the Department's designated contact for Direct Care Workers to submit questions, concerns or complaints regarding the base wage requirement.

4. Providers shall submit specific information for each Direct Care Worker regarding wage rates, working hours, benefits, work location, employment status, employment type, services provided, independent contractor agreements, and any other wage related information as requested by the Department. Providers shall submit the requested information within the Department-specified timeframe.

5. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the applicable services received at a minimum the base wage or a per diem wage increase.

6. Records shall be retained for no less than six (6) years and shall be made available for inspection by the Department upon request. Records may include, but are not limited to:

   a. Payroll summaries and details, pay stubs with details

   b. Timesheets

   c. Paid time off records

   d. Cancelled checks (front and back)

   e. Direct deposit confirmations

   f. Independent contractor documents or agreements

   g. Per diem wage documents

   h. Accounting records such as: accounts receivable and accounts payable

D. Base Wage Requirement for Direct Care Workers Reporting & Auditing Requirements

1. The Department has ongoing discretion to request information from providers to demonstrate that all Direct Care Workers receive the required wage. All records related to the wage requirements for the applicable services shall be made available to the Department upon request, within specified deadlines.

2. Providers shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department. Incomplete or invalid submissions will be returned to Providers for corrections.

3. Failure to submit Direct Care Worker information as required or failure to provide adequate documents and timely responses may result in the Provider being required to submit a plan of correction and/or be subject to an overpayment or penalty recovery. The Department may suspend payment of claims until requested information is received and approved by the Department.

4. If a plan of correction is requested by the Department, the Provider shall submit the plan of correction by the date specified by the Department. The Provider must notify the Department in writing within five (5) business days of receipt of the request if they will not be able to meet the deadline. The Provider must explain the rationale for the delay and the Department may or may not grant an extension in writing.

5. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider must resubmit a new plan of correction along with any requested documentation to the Department for review within five (5) business days of notification.

6. The Department may recoup funds paid to the Provider relating to the base wage increase or impose a penalty, if the Department determines the Provider is not in compliance with Section 8.7418.

7. If such determination is made to recoup funds, the Provider will be notified by the Department. All recoupments will be conducted pursuant to C.R.S. Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.050.6, Informal Reconsideration and Appeals of Overpayments Resulting from Review or Audit Findings.

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 services and requirements under the Home and Community-Based Services (HCBS) Waivers.

8.7502 Definitions: Unless otherwise specified, the following definitions apply throughout Section 8.7000 et seq.

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

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

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

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

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

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

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

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

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

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

K. 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. Financial Eligibility is as defined at Section 8.7100.A.28.

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

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

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

P. 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. 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. Legally Authorized Representative is as defined at 8.7001.A.7.

S. Long Term Services and Supports Representative is as defined at Section 8.7001.A.~~7~~8.

T. Member is as defined at ~~8.7200.B.22~~8.7001.A.9.

U. Person-Centered Support Plan is as defined at 8.7100.A.11.

V. Prior Authorization Request (PAR) is as defined at 8.7402.Q.

W. Provider Agency is as defined at 8.7100.A.52.

X. Restraint is as defined at Section 8.7001.A.1~~5~~6.

Y. 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.

Z. Waiver is as defined at section 8.7200.B.31

AA. Waiver Service is as defined at 8.7100.A.68.

8.7503~~2~~ Acupuncture

8.7503~~2~~.A Acupuncture Eligibility

1. Acupuncture is a covered benefit available to Members enrolled in the HCBS Complementary and Integrative Health Waiver.

8.7503~~2~~.B Acupuncture Definition

1. Acupuncture means the insertion of needles and/or manual, mechanical, thermal, electrical, and electromagnetic treatment to stimulate specific anatomical tissues for the promotion, maintenance and restoration of health and prevention of disease both physiological and psychological. During an acupuncture treatment, dietary advice and therapeutic exercises may be recommended in support of the treatment.

8.7503~~2~~.C Acupuncture Inclusions

1. Acupuncture is used for treating conditions or symptoms related to the Member's qualifying condition and Inability to Independently Ambulate.

2. Members receiving acupuncture and other complementary and integrative health services shall be asked to participate in an independent evaluation to determine the effectiveness of the services.

3. Acupuncture shall be provided in the clinic or office of a licensed acupuncturist, an approved outpatient setting, or in the Member's residence.

8.75032.D Acupuncture Exclusions and Limitations

1. Acupuncture shall be limited to the Member's assessed need for services as identified and documented in the Person-Centered Support Plan.

2. A maximum of 408 combined units of Acupuncture, Chiropractic, and Massage Therapy Waiver Services may be covered as a benefit during the ~~Person-Centered S~~support ~~Plan year~~plan year.

8.75032.E Acupuncture Service Provider Agency Requirements

1. Acupuncture providers shall be licensed pursuant to § 12-200-101 et seq (C.R.S) and have at least 1 year of experience practicing Acupuncture at a rate of 520 hours per year; OR 1 year of experience working with individuals with paralysis or other long term physical disabilities.

2. Acupuncture Provider Agencies shall:

   a. Determine the appropriate modality, amount, scope, and duration of acupuncture within the established limits as described at Section 8.75032.D.2.

   b. Recommend only services that are necessary and appropriate in a ~~plan of care~~service plan that the Provider Agency ~~will~~ submits to the Member's Case Manager.

   c. Provide only services in accordance with the Member's prior authorized units.

8.75043 Adaptive Therapeutic Recreational Equipment and Fees

8.75043.A Adaptive Therapeutic Recreational Equipment and Fees Eligibility

1. Adaptive Therapeutic Recreational Equipment and Fees is a covered benefit available to Members enrolled in the HCBS Children's Extensive Supports Waiver.

8.75043.B Adaptive Therapeutic Recreational Equipment and Fees Definition

1. Adaptive ~~t~~Therapeutic ~~r~~Recreational ~~e~~Equipment and ~~f~~Fees assist a Member in recreating within the Member's community. These services include recreational equipment that is adapted specific to the Member's disability and not items that a typical age peer would commonly need as a recreation item.

8.75043.C Adaptive Therapeutic Recreational Equipment and Fees Inclusions

1. Adaptive Therapeutic Recreational Equipment and Fees is authorized for Organized Health Care Delivery Service (OHCDS) as outlined at Section 8.7202.W.

2. Adaptive therapeutic recreational equipment may include an adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices

and other types of equipment appropriate for the recreational needs of a Member with a Developmental Disability.

~~2~~3. A pass for admission to a recreation center for the Member is covered only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased in the most cost effective method available ~~as day passes or monthly passes, whichever is the most cost effective.~~

~~3~~4. Adaptive therapeutic recreation fees include those for water safety training.

8.7504~~3~~.D Adaptive Therapeutic Recreational Equipment and Fees Exclusions and Limitations

1. The following items are specifically excluded and not eligible for reimbursement:
    a. Entrance fees for:
        i. Zoos;
        ii. Museums;
        iii. Movie theaters, performance theaters, concerts, other entertainment venues; and
        iv. Professional and minor league sporting events.
    b. Outdoor play structures; and
    c. Batteries for recreational items.

8.7504~~3~~.E Adaptive Therapeutic Recreational Equipment and Fees Reimbursement

1. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is $1,000.00 per ~~Person-Centered S~~support ~~P~~plan year.

8.7505~~4~~ Adult Day Services

8.7505~~4~~.A Adult Day Services Eligibility

1. Adult Day Services (ADS) is a covered benefit available to Members enrolled in one of the following HCBS waivers:
    a. Brain Injury Waiver
    b. Community Mental Health Services Waiver
    c. Complementary and Integrative Health Waiver
    d. Elderly, Blind, and Disabled Waiver

8.7505~~4~~.B Adult Day Services Descriptions and Definitions pertaining to Section 8.7505

1. Adult Day Services (ADS) Centers are certified centers that provide Basic Adult Day Services and Specialized Adult Day Services to Members.
2. Adult Day Services (ADS) may be provided out of an Adult Day Services Center or through Non-Center-Based means including Telehealth.

3. Adult Day Services ~~ADS~~ are provided on a regularly scheduled basis. Services must be delivered as specified in the Member's service plan~~the Person-Centered Support Plan~~, and promote social, recreational, physical, and emotional well-being, and shall encompasses the supportive services needed to ensure the optimal wellness of the Member.

4. Basic Adult Day Services (ADS) Center means a community-based entity that provides basic Adult Day Services.

5. Center-Based Adult Day Services are services provided in a certified ADS Center.

~~6.~~ ~~Direct Care Staff means staff who provide hands-on care and services, including personal care, to Members. Direct Care Staff must have the appropriate knowledge, skills, and training to meet the individual needs of the Members before providing care and services.~~

6~~7~~. Licensed Medical Professional for Section 8.7505 Adult Day Services only means the primary care provider of the Member, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA), Advanced Practicing Nurse (APN). Registered Nurse (NR), or Licensed Practical Nurse (LPN). License Medical Professional practices shall adhere the Colorado Medical Practice Act or the Colorado Nurse Practice Act, as applicable to the professional licensure category.

~~7~~7.~~.~~ Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where Members may engage in activities and community life, either in-person or through virtual means.

8~~-9~~8. Specialized Adult Day Services (SADS) Center means a community-based entity providing Adult Day Services for Members with a primary diagnosis of dementia related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington's Disease, Parkinson's, or post-stroke Members, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have ~~a~~ one of any of these diagnoses. Each diagnosis must be verified by a Licensed Medical Professional either directly or through Case Management Agency documentation, in accordance with Section 8.75054.E.9.

~~9~~9.10. Telehealth Adult Day Services are services provided through virtual means in a group or on an individual basis. Telehealth ADS allows for Members to engage in activities with their community and connect to staff and other ADS Members virtually or over the phone, only if a Member does not have access or the ability to use video chat technology. Nutrition services are not required to be included in Telehealth Services.

8.75054.C Adult Day Services Inclusions

1. Only Members whose needs may be met by the ADS ~~p~~Provider Agency within its Certification category and populations served may be admitted by the ADS ~~p~~Provider Agency.

2. A Member can receive either Center-Based ADS, Non-Center-Based ADS, or a combination of Center-Based ADS and Non-Center-Based ADS within the same week.

~~3. For ADS, a Licensed Medical Professional also includes a Registered Nurse (RN) or Licensed Practical Nurse (LPN) that possesses one or more active, and in good standing, Colorado licenses governed by the Colorado Nurse Practice Act.~~

43. ADS for all waivers shall include, but are not limited to:

a. Assistance with Activities of Daily Living (ADL), as needed when ADS is provided in-person; monitoring of the Member's health status and personal hygiene; assistance with administering medication and medication management (administration of medication only during the in-person delivery of services); and carrying out physicians' orders as set forth in Member's individual Person-Centered Support Plan.

b. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.

54. Nutrition services including therapeutic diets and snacks in accordance with the Member's individual Person-Centered Support Planservice plan and hours of attendance. Nutrition services are not required during the delivery of Non-Center-Based ADS.

65. Age-appropriate social and recreational supportive services as appropriate for each Member and their needs, as documented in the Member's Person-Centered Support Planservice plan. Activities shall take into consideration individual differences in age, health status, sensory deficits, religious affiliation, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.

76. Members have the right to choose not to participate in social and recreational activities.

8.75054.D Specialized Adult Day Services

1. The Member's Person-Centered Support Plan and Provider Agency service plan must include documentation of their diagnosis(es) and service goals.

2. A Specialized Adult Day Services (SADS) pProvider Agency must verify all Medicaid Member's diagnosis(es) using the Professional Medical Information Page (PMIP) which shall be supplied by the Case Manager or by documentation from the Member's Licensed Medical Professional. SADS pProvider Agencies must ensure documentation verifying the Member's diagnosis(es) is obtained at the time of admission and whenever there is a significant change in the Member's condition. The SADS pProvider Agency shall record any significant change to the Member's condition must be recorded in the Member's record or Person-Centered Support Planservice plan.

3. For Members from payment sources other than Medicaid, diagnosis(es) must be documented in a Person-Centered Support Planservice plan or other admission form and verified by the Member's physician or Licensed Medical Professional. This documentation must be verified at the time of admission, and whenever there is a significant change in the Member's condition.

4. Adult Day Services Exclusions and Limitations

a. The delivery of a meal, workbook, activity packet, etc. Or similar materials, does not constitute ADS and is not a covered unless in-person ADS service is provided in addition to the delivery of food or itemmaterials.

8.75054.E Adult Day Services Provider Agency Requirements

1. General

a. Adult Day Services providers shall be Medicaid certified by the Department in accordance with Section 8.7403.A. Proof of Medicaid Certification consists of an

approved Provider Agreement by the Department and the Department's fiscal agent, and a recommendation for Certification from the Colorado Department of Public Health and Environment (CDPHE).

2. Environment

   a. Adult Day Services Centers shall provide recreational areas and activities appropriate to the number and needs of the Members, at the times desired by the Members.

   b. Adult Day Services Centers shall provide for a private shower and/or bathing area located on site to address the emergency hygiene needs of Members as needed.

   c. To accommodate the activities and program needs of the ADS Center, the center shall provide eating and activity areas that are consistent with the number and needs of the Members being served, at a minimum of 40 square feet per Member.

   d. ADS Centers shall maintain a comfortable temperature throughout the center. At no time shall the temperature fall outside the range of 68 degrees to 76 degrees Fahrenheit.

   e. ADS Centers shall provide an environment free from Restraints.

   f. ADS Centers shall provide a safe environment for all Members, including Members exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

3. Food Safety Requirements

   a. ADS providers shall comply with all applicable local food safety regulations. In addition, all ADS Centers shall ensure:

      i. Access to a handwashing sink, soap, and disposable paper towels;

      ii. Food handlers, cooks, and servers, including Members engaged in food preparation, wash their hands according to food safety hand-washing guidelines;

      iii. The ADS Centers shall not allow any staff or Members who are not in good health and free of communicable disease to handle, prepare or serve food or handle utensils;

      iv. Refrigerated foods opened or prepared and not used within 24 hours are marked with a "use by" or "discard by" date. The "use by" or "discard by" date may not exceed 7 days following opening or preparation, or exceed or surpass the manufacturer's expiration date for the product or its ingredients;

      v. Foods provided as food service are maintained at the proper temperatures at all times. Foods that are stored cold must be held at or below 41 degrees Fahrenheit and foods that are stored hot must be held at or above 135 degrees Fahrenheit in order to control the growth of harmful bacteria;

         1) Kitchen and food preparation equipment shall be maintained in working order and cleanable; and

         2) Any equipment or surfaces used in the preparation and service of food shall be washed, rinsed, and sanitized before use or at least every 4 hours of continual use. Dish detergent shall be labeled for its intended

purpose. Sanitizer shall be approved for use as a no-rinse food contact sanitizer. Sanitizers shall be registered with the Environmental Protection Agency (EPA) and used in accordance with labeled instructions.

4. Medication Administration and Monitoring

~~a~~a. Adult Day Service ~~p~~Providers Agencies shall comply with Medication Administration regulations in Section 8.7414.

5. Records and Information

a. All ADS ~~p~~Providers Agencies shall keep records and information necessary to document the services provided to Members receiving Adult Day Services, as required in Section 8.7405. In addition to the requirements at Section 8.7405, ADS records must also include:

i. Name, address, and telephone number of primary physician;

ii. Documentation of the supervision and monitoring of services provided;

iii. Documentation that all Members and their Guardian or other Legally Authorized Representative, if authorized/if within the scope of their authority have been oriented to the ADS Center, their policies and procedures, to the services provided by the ADS provider, and delivery methods offered;

iv. A service agreement signed by the Member and/or the Guardian or other Legally Authorized Representative, if authorized/if within the scope of their authority and appropriate Adult Day Services staff;

v. For SADS providers only, a copy of the Professional Medical Information Page, or documentation of diagnosis from the Member's Licensed Medical Professional; and

vi. Documentation specifically stating the types of services and monitoring that are provided when rendered via Telehealth, ensuring the integrity of the service provided and the benefit the service provides the Member.

6. ~~Person-Centered Support~~Service Plan

a. The ADS Provider Agency shall document the following information in a service plan, which shall be used to direct the Member's care ~~in the Person-Centered Support Plan~~.

i. Medical Information:

1) All medications prescribed for the Member, including those used by the Member while receiving Center-Based or Non-Center-Based ADS, and whether the medication is self-administered;

2) Special dietary considerations or instructions;

3) Services that are administered to the Member while receiving Center-Based and/or Non-Center-Based ADS, which may include nursing or medical interventions, speech therapy, physical therapy, or occupational therapy;

a) Any recommended restrictions on social and/or recreational activities identified by Member's Licensed Medical Professional; and

b) Any other special health or behavioral management services or supports recommended to assist the Member by the Member's Licensed Medical Professional.

4) Even if recommended by the Member's Licensed Medical Professional, staff interventions that interfere with the Member's choice of food, freedom to determine their own activities, or exercise of any other rights are Rights Modifications for which the ADS ~~p~~Provider Agency must comply with Section 8.7001.B.4.

ii. ~~Person-Centered Support~~Service Planning Documentation:

1) Documentation that the Member and/or Guardian or other Legally Authorized Representative, if authorized/if within the scope of their authority, selected the ADS Provider Agency.

2) Individual choices, including location and delivery method for ADS, preferences, and needs shall be incorporated into the goals and services outlined in a service plan~~the Person-Centered Support Plan~~;

3) All Member information and the ~~Person-Centered Support Plan~~ service plan are considered Protected Health Information and shall be kept confidential; and

4) The Member and/or Guardian or other Legally Authorized Representative, must review and sign the service plan and Person-Centered Support Plan.

5) Any modifications to the Person-Centered Support Plan or service plan must comply with Section 8.7001.B.4.

6) Documentation as to whether the Member has executed an advance directive or other declaration regarding medical decisions.

7. Staff Requirements

a. In determining appropriate staffing levels, the Adult Day Services Provider Agency shall adjust staffing ratios based on the individual acuity and needs of the Members being served. At a minimum, staffing must be sufficient in number to provide the services described in the service plans~~Person-Centered Support Plans~~, considering the individual needs, level of assistance, and risks of accidents. A staff person may perform multiple functions, if those functions are consistent with the definition of Direct Care Worker~~Staff~~, Section 8.75054.B.6. Staff counted in the staff-Member ratio are those who are trained and able to provide direct services to Members.

i. Center-Based and in-person, Non-Center-Based ADS shall be staffed at a minimum of 1 staff to 8 Members with continuous supervision of Members during program operation.

ii. Telehealth ADS shall be staffed at a minimum of 1 staff to 15 virtual Members with continuous virtual supervision of Members during Telehealth program operation.

b. Staff shall provide:

i. Immediate response to emergency situations to assure the safety, health, and welfare of Members;

ii. Activities that are planned to support the ~~Person-Centered Support Plans~~service plan for the Members.

iii. Administrative, recreational, social, and supportive functions and duties.

iv. Nursing services for regular monitoring of the on-going medical needs of Members and the supervision of medications. These services must be available a minimum of two hours daily during Center-Based ADS and as needed for Non-Center-Based Adult Day Services.

v. Nursing services shall be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Certified Nursing Assistants (CNA) may provide nursing services under the direction of a RN or an LPN, in conformance with delegation provisions at in § 12-38-132, C.R.S. Supervision of CNAs must include documented consultation and oversight on a weekly basis or more frequently according to the Member's needs. If the supervising RN or LPN is an ADS Staff Member with consultation and oversight of CNAs included in the Member's job description, the supervising nurse's documented attendance at the ADS center during times when nursing services are provided shall be sufficient to document consultation and oversight.

c. In addition to the above services, Specialized Adult Day Services (SADS) Centers shall have sufficient staff to provide nursing services during all hours of operation.

8. Director Qualifications

a. All Directors shall meet one of the following qualifications:

i. At least a bachelor's degree from an accredited college or university and a minimum of two years of social services or health services experience and shall have demonstrated ability to perform all aspects of the position; or

ii. An LP~~M~~N or RN license issued by the state of Colorado and completion of two years of paid or volunteer experience in planning or delivering health or social services including experience in supervision and administration; or

iii. A high school diploma or GED equivalent, a minimum of four years of experience in a social services or health services setting, acquired skills in working with aging adults or adults with functional impairment, and skills required to supervise ADS Center staff persons.

9. Training Requirements

a. All staff and volunteers shall be trained in accordance with Section 8.7409.D. and in the use of Universal Precautions and infection control, as defined at Section 8.7502.Y.

b. Direct Care Workers~~Staff~~ shall complete training prior to the provision of services.

10. Dementia Training Requirements

a. As of October 1, 2023, each Adult Day Services provider shall ensure that its Direct -Care Worker~~Staff~~ Members complete dementia training as required by Section 25.5-6-314, C.R.S.

b. Definitions: applicable to Dementia Training Requirements: In addition to those definitions set forth at Section 25.5-6-314, C.R.S., the following definitions apply:

i. "Covered Facility" means a nursing care facility or an assisted living residence licensed by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a).

ii. "Dementia diseases and related disabilities" is a condition where mental ability declines and is severe enough to interfere with an individual's ability to perform everyday tasks. Dementia diseases and related disabilities include Alzheimer's disease, mixed dementia, Lewy Body Dementia, vascular dementia, frontotemporal dementia, and other types of dementia.

iii. "Direct -Care ~~Staff~~Worker ~~Member~~" means a Staff Member caring for the physical, emotional, or mental health needs of Members of an Adult Day Services provider and whose work involves regular contact with Members who are living with Dementia Diseases and related disabilities.

iv. "Staff Member" means an individual, other than a volunteer, who is employed by an Adult Day Services provider.

v. "Equivalent training" means any initial training provided by a Covered Facility that meets the requirements in Section 8.75054.E.10.c. If the Equivalent Training was provided more than 24 months prior to the date of hire as allowed in the exception found in Section 8.75054.E.10.d., the individual must document participation in both the Equivalent Training and all required continuing education subsequent to the initial training.

c. Initial training: Each Adult Day Services provider is responsible for ensuring that all Direct -Care Workers~~Staff Members~~ are trained in dementia diseases and related disabilities.

i. Initial training shall be available to ~~Direct Care Staff Members~~Direct Care Workers at no cost to them.

ii. The training shall be competency-based and culturally competent and shall include a minimum of four hours of training in dementia topics including the following content:

1) Dementia diseases and related disabilities;

2) Person-centered care;

3) Care planning;

4) Activities of Daily Living; and

5) Dementia-related behaviors and communication.

iii. For ~~Direct Care Staff Members~~Direct Care Workers already employed prior to October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after October 1, 2023, unless an exception, as described in Section 8.750~~4~~5.E.10.d.i. applies.

iv. For ~~Direct Care Staff Members~~Direc Care Workers hired or providing care on or after October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after the start of employment or the provision of direct-care services, unless an exception, as described in Section 8.750~~5~~4.E.10.d.ii applies.

d. Exception to initial dementia training requirement

i. Any D~~irect Care Staff Member~~Direct Care Worker who is employed by or providing direct-care services prior to the October 1, 2023, may be exempted from the provider's initial training requirement if all of the following conditions are met:

1) The ~~Direct Care Staff Member~~Direct Care Worker has completed Equivalent Training program, as defined in these rules, within the 24 months immediately preceding October 1, 2023; and

2) The ~~Direct Care Staff Member~~Direct Care Worker may provide documentation of the satisfactory completion of the Equivalent Training program.

ii. Any ~~Direct Care Staff Member~~Direct Care Worker who is hired or begins providing direct-care services on or after October 1, 2023, may be exempted from the provider's initial training requirement if the ~~Direct Care Staff Member~~Direct Care Worker:

1) Has completed an equivalent initial dementia training program, as defined in these rules, either:

a) Within the 24 months immediately preceding October 1, 2023; or

b) Within the 24 months immediately preceding the date of hire or the first date the ~~Direct Care Staff Member~~Direct Care Worker provides direct care services; and

2) Provides documentation of the satisfactory completion of the equivalent initial training program; and

3) Provides documentation of all required continuing education subsequent to the initial training.

iii. Such exceptions shall not exempt a ~~Direct Care Staff Member~~Direct Care Worker from the requirement for dementia training continuing education as described in Section 8.750~~4~~5.E.10.e.

e. Dementia Training: Continuing Education

i. After completing the required initial training, all ~~Direct Care Staff Members~~Direct Care Workers shall have completed and documented a minimum of two hours of continuing education on dementia topics every two years.

ii. Continuing education on this topic shall be available to ~~Direct Care Staff Members~~Direct Care Workers at no cost to them.

iii. This continuing education shall be culturally competent, include current information provided by recognized experts, agencies, or academic Institutions, and include best practices in the treatment and care of persons living with dementia diseases and related disabilities.

f. Minimum requirements for individuals conducting dementia training:

i. Specialized training from recognized experts, agencies, or academic Institutions in dementia disease, or

ii. Successful completion of other similar training which meets the minimum standards described herein; and

iii. Two or more years of experience working with persons living with dementia diseases and related disabilities.

g. Documentation of initial dementia training and continuing education for ~~Direct Care Staff Members~~Direct Care Workers:

i. The ~~p~~Provider Agency shall maintain documentation that each ~~Direct Care Staff Member~~Direct Care Worker has completed initial dementia training and continuing education. Such records shall be made available upon request.

ii. Completion shall be demonstrated by a certificate, attendance roster, or other documentation reliably demonstrating completion of training.

iii. Documentation shall include the number of hours of training, the date on which it was received, and the name of the instructor and/or training entity.

iv. Documentation of the satisfactory completion of an equivalent initial training program shall include the information required in this Section 8.75045.E.10.g.ii. & iii.

v. After the completion of training and upon request, such documentation shall be provided to the Staff Member for their use in obtaining employment at another Covered Facility. For the purposes of dementia training documentation, Covered Facilities shall include Assisted Living Residences, and Nursing Care Facilities pursuant to § 25.5-6-314, C.R.S, and Adult Day Care Facilities as defined in § 25.5-6-303(1), C..R.S.

11. Written Policies

a. In addition to the policies and procedures described in Section 8.7408, the ADS provider shall maintain written policies and procedures relevant to the operation of Adult Day Services. Such policies shall include, but not be limited to, statements describing:

i. Admission criteria for Members shall can be appropriately served by the Adult Day Services Provider Agency;

ii. Intake procedures conducted for Members and/or Guardian or other Legally Authorized Representative, if authorized/if within the scope of their authority prior to admission with the ADS provider;

iii. The meals and nourishments, including special diets, that are provided at Center-Based Adult Day Services;

iv. The hours and days that Center-Based Adult Day Services are open and available, and the days and times that Non-Center-Based Adult Day Services are available to Members, including the availability of nursing services;

v. The personal items that the Members may bring with them to the Adult Day Services Center; and

vi. The administration of Telehealth Adult Day Services, if provided. This includes Telehealth options, provision of services, and examples of services offered in a virtual setting.

b. There shall be a written, signed agreement between the Member and/or Guardian or other Legally Authorized Representative, if authorized/if within the scope of their authority and the Adult Day Services ~~p~~Provider Agency outlining the rules and responsibilities of the Adult Day Services ~~p~~Provider Agency and the Member. The Adult Day Services Provider Agency shall provide a copy of the agreement to each party to the agreement.

8.750~~5~~4.F Adult Day Services Provider Agency Reimbursement Requirements

1. Reimbursement for Adult Day Services ~~ADS~~ for Members in the HCBS Elderly, Blind and Disabled (EBD), Community Mental Health Supports (CMHS), and the Complementary and Integrative Health (CIH) waivers is to be billed in accordance with the current rate schedule:

   a. ADS Provider Agencies may bill in 15-minute units or for 1-2 units of 3-5-hours depending on the Member's needs and how the service is delivered.

      i. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 12 units or three (3) hours per day of Basic Adult Day Services.

      ii. A ~~p~~Provider Agency may bill the maximum of 15-minute units for ADS in combination with no more than 1 unit of 3-5 hour ADS on the same day, as long as services were rendered at separate times.

2. For persons in the HCBS waiver for Persons with a Brain Injury (BI), reimbursement for BI- Adult Day Services ~~ADS~~ is to be billed in accordance with the current rate schedule.

   a. A unit is defined as the following:

      i. Adult Day Services Provider Agencies may bill in units of 15 minutes or a unit of 2 or more hours depending on the Member's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 8 units or two (2) hours per day of services.

ii. Units of 2 hours or more delivered only in-person. An ADS provider cannot bill for 15-minute units of ADS if a unit of 2-hour BI ADS was provided to the same Member on the same day.

3. Adult Day Services ~~ADS~~ Centers are permitted to utilize funding from other Federal sources, such as the Child and Adult Care Food Program (CACFP), in addition to the Medicaid per diem. If such funding is utilized, a Center must acknowledge the use of multiple funding sources and demonstrate that the services funded by a federal source do not duplicate Medicaid-funded services.

4. Only providers certified as a Specialized Adult Day Services Center are permitted to receive the SADS reimbursement rate. The SADS reimbursement rate applies to every Member at a SADS Center, even if the Member does not have a specialized diagnosis.

5. Certified SADS providers may provide Non-Center-Based Adult Day Services, including Telehealth ADS Non-Centered-Based Adult Day Services, shall be billed only as Basic Adult Day Services using the 15-minute unit, up to 3 hours per day. The SADS provider may bill the maximum of 15-minute units for Basic Adult Day Services ~~ADS~~ in combination with no more than 1 unit of 3-5 hour SADS on the same day, as long as services were rendered at separate times.

6. Provider Agencies shall not bill for services on the same day of service for a Member in an HCBS residential program, unless the following criteria have been met:

   a. Adult Day Services ~~ADS~~ and residential services have been authorized by the Department and are included in an approved Prior Authorization Request PAR;

   b. Documentation from the Member's physician demonstrates the required specialized services in the Adult Day Services ~~ADS~~ Center are necessary because of the Member's diagnosis(es), are essential to the care of the Member, and are not included in the residential per diem;

   c. Documentation that the extensive rehabilitative therapies and therapeutic needs of the Member are not being met by the residential program and are not included in the residential per diem; and

   d. Documentation from the Member's physician recommends Adult Day Services ~~ADS~~ and describes how it will meet the previously mentioned needs.

8.750~~6~~5 Alternative Care Facility

8.750~~6~~5.A Alternative Care Facility Eligibility

1. Alternative Care Facility is a service available to Members enrolled in one of the following HCBS waivers:

   a. Community Mental Health Services Waiver

   b. Elderly, Blind, and Disabled Waiver

8.750~~6~~5.B Alternative Care Facility Definitions pertaining to Section 8.7506

1. Alternative Care Facility authorized in § 25.5-6-303(3), C.R.S., means an Assisted Living Residence as defined at 6 CCR 1011-1, Chapter VII, Section 2, which has been licensed by the

Colorado Department of Public Health and Environment (CDPHE) and certified by the Department to provide Alternative Care Services to Medicaid Members.

a. Alternative Care Services as described in § 25.5-6-303(4), C.R.S., means a package of personal care and homemaker services provided in a state licensed and certified alternative care facility including, but not limited to: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding, ambulation, transfers, positioning, bladder & bowel care, medication reminding and monitoring, accompanying, routine house cleaning, meal preparation, bed making, laundry, shopping, ~~.~~ m~~M~~edication administration ~~describes~~ and protective oversight.

2. Protective oversight means monitoring and guidance of a Member to assure their health, safety, and well-being. Protective oversight also includes but is not limited to: monitoring the Member while on the premises of service setting, monitoring the Members' needs, and ensuring that the Member receives the services and care necessary to protect their health and welfare. Protective oversight shall be no more intrusive than necessary to protect the health and welfare of the Member and others. If protective oversight for a Member entails Intensive Supervision as defined at Section 8.7001.A.6 or otherwise limits a Member's privacy, autonomy, access to the community, or other rights, then the Alternative Care Facility shall follow the Rights Modification process at Section 8.7001.B.4.

8.750~~6~~5.C ~~Alternat~~Alternative~~e~~ Care Facility Inclusions

1. Member Eligibility

a. Members enrolled in the HCBS Elderly, Blind and Disabled (EBD) and the HCBS Community Mental Health Supports (CMHS) Waivers to are eligible to receive services in an Alternative Care Facility.

i. Potential Members shall be assessed, at a minimum, by a team that includes the Member and/or Guardian or other Legally Authorized Representative, the Alternative Care Facility administrator or appointed representative, and Case Management Agency Case Manager to determined that the Alternative Care Facility is an appropriate community setting that will meet the Member's choice and need for independence and community integration. If one of the parties listed above is not available, input or information must be obtained from each party prior to making an admission determination. The team may also include Family Members, Accountable Care Collaborative or Mental Health Center Case Managers, and any other interested parties as approved by the Member.

1) An ~~A~~assessment shall be conducted prior to admission, annually, whenever there is a significant change in physical, cognitive, or behavioral needs, or as requested by the Member. The annual ~~A~~assessment must be completed by the team described in Sections 8.750~~5~~6.C.1.a.i.

2) The ~~A~~assessment shall document that the setting will support the Member and their needs. The assessment shall also document the Member's physical, behavioral and social needs, so that supports can be identified to enable them to lead as independent a life as possible. The

assessment shall be used to develop the Member's ~~Person-Centered Support Plan~~service plan.

8.750~~65~~.D Alternative Care Facilities Member Benefits

1. Alternative Care Services described at Section 8.750~~5~~6.B.1.a are benefits to Members residing in an Alternative Care Facility .

    a. When Medication Administration is provided as an Alternative Care Service reimbursement for Medication Administration is included in the reimbursement rate for Alternative Care Services and shall not be billed separately for Alternative Care Facility services.

2. Alternative Care Facility ~~p~~Provider Agencies shall not provide additional services which are available as a6 State Plan benefit or other Community Mental Health Supports (CMHS) or Elderly, Blind, and Disabled (EBD) waiver service.

3. Alternative Care Facility ~~p~~Provider Agencies shall provide Member engagement opportunities described in 6 CCR 1011-1, Chapter VII, Part 13.1(C).

8.750~~65~~.E Alternative Care Facility Member Rights

1. Alternative Care Facility ~~p~~Provider Agencies shall inform Members of their rights, as set forth at 6 CCR 1011-1, Chapter VII, Part 13 and Section 8.7001. Any modification of those rights shall be in accordance with Section 8.7001.B. Pursuant to 6 CCR 1011-1, Chapter VII, Part 13.1, the policy on resident rights shall be in a visible location so that they are always available to Members and visitors.

2. Even if recommended by the Member's physician, staff interventions that interfere with the Member's choice of food, freedom to determine their own activities, or exercise of any other rights are Rights Modifications that may only be implemented following compliance with Section 8.7001.B.4.

3. Alternative Care Facility ~~p~~Provider Agencies shall inform Members of all Alternative Care Facility policies upon admission to the setting, and when changes to policies are made Rules and/or policies shall apply consistently to the administrator, staff, volunteers, and Members residing in the facility and their Family or friends who visit. Alternative Care Facility ~~p~~Provider Agencies shall document Member acknowledgement of rules and policies in ~~the Person-Centered Support Plan~~a service plan or a resident agreement.

4. If requested by the Member, the Alternative Care Facility shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, a chair and a dresser and a way to secure personal possessions.

5. Alternative Care Facility ~~p~~Provider Agencies shall not discontinue services to a Member unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services in accordance with 6 CCR 1011-1, Ch. VII Section 11.

6. Alternative Care Facility ~~p~~Provider Agencies shall inform Members of the setting's policies and procedures for implementation of an individual's advance directives.

7. Alternative Care Facility ~~p~~Provider Agencies shall not require Medicaid Members to take part in performing household cleaning or maintenance tasks.

8.750~~65~~.F Alternative Care Facility Provider Agency Requirements

1. Alternative Care Facility Provider Agencies shall be licensed in accordance with 6 CCR 1011-1, Chapters II and VII and obtain an Alternative Care Facility Certification prior to enrollment with the Department.

2. Member Engagement

   a. In consultation with Members served, Alternative Care Facility Provider Agencies shall provide social and recreational engagement opportunities both within and outside the setting.

      i. Opportunities for social and recreational engagement shall take into consideration the individual interests and wishes of the Members.

      ii. In determining the types of opportunities and activities offered, the ~~p~~Provider Agencies shall consider the physical, social, and mental stimulation needs of the Members.

3. Member Leave

   a. Alternative Care Facility Provider Agencies shall notify the Member's Case Manager of any Member planned or unplanned non-medical and/or programmatic leave of a duration greater than 24 hours.

b. The therapeutic and/or rehabilitative purpose of leave shall be documented in the Member's ~~Person-Centered Support~~service ~~P~~plan.

4. ~~Person-Centered Support~~Service ~~P~~plan

   a. The following information must be documented in ~~the Person-Centered Support P~~the Member's service plan:

      i. Medical Information:

         1) Medications the Member takes and how they are administered, with reference to the Medication Administration Record (MAR);

         2) Special dietary needs, if any; and

         3) Physician orders.

      ii. Social and recreational engagement:

         1) The Member's preferences and current relationships; and

         2) Any recommended restrictions on social and/or recreational activities identified by a physician.

      iii. Any other special health or behavioral management needs that support the Member's individual needs.

b. Additional ~~Person-Centered Support Planning~~Service Plan Documentation:

i. Documentation from the admission process which demonstrates that the setting was selected by the Member;

ii. Identification of the Member's goals, choices, preferences, and needs and incorporation of these elements into the supports and services described in the Person-Centered Support Plan;

iii. Any modifications to the Member's rights, with the required supporting documentation; and

iv. Evidence the Member and/or their Guardian, or other Legally Authorized Representative has had the opportunity to participate in the development of the ~~Person-Centered Support Plan~~service plan, as evidenced by the Member or other Legally Authorized Representatives' signature on the service plan.

5. Environmental Standards

a. The Alternative Care Facility shall be an environment that supports individual comfort, independence, and preference, maintains a home-like quality and feel for Members at all times, and provides Members with unrestricted access to the Alternative Care Facility in accordance with the residency agreement or modifications as agreed to and documented in the Member's service plan ~~Person-Centered Support Plan~~.

b. Alternative Care Facilities shall provide an outdoor area accessible to Members without staff assistance that is well maintained, facilitates community gatherings, and is appropriately equipped for the population served.

c. Alternative Care Facilities shall maintain a comfortable temperature throughout the Alternative Care Facility and Member rooms, sufficient to accommodate the use and needs of the Members, never to fall outside the range of 68 degrees to 76 degrees Fahrenheit.

d. The Alternative Care Facility shall develop and follow written policies and procedures to ensure the continuation of necessary care to all Members for at least 72 hours immediately following any emergency including, but not limited to, a long-term power failure.

e. The Alternative Care Facility ~~p~~Provider Agency shall display the monthly schedule of daily recreational and social engagement opportunities in a visible location so that it is always available to Members and visitors, and developed in accordance with 6 CCR 1011-1, Chapter VII, Section 12.26, pertaining to Member Engagement.

i. Staff shall be responsible for ensuring that the daily schedule of recreational and social engagement opportunities is implemented and offered to all Members.

f. The Alternative Care Facility ~~p~~Provider Agency shall provide reading material in the common areas at all times, reflecting the interests, hobbies, and requests of the Members.

g. The Alternative Care Facility ~~p~~Provider Agency shall provide nutritious food and beverages that Members have access to at all times. Access to food and cooking of food shall be in accordance with 6 CCR 1011-1, Chapter VII, Section 17.1-3. The access to food shall be provided in at least one of the following ways:

i. Access to the Alternative Care Facility kitchen.

ii. Access to an area separate from the Alternative Care Facility kitchen stocked with nutritious food and beverages.

iii. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the Member's bedroom.

iv. A safe, sanitary way to store food in the Member's room.

h. The Alternative Care Facility ~~p~~Provider Agency shall assess each Member's cooking capacity shall be assessed as part of the pre-admission process and updated in the ~~Person-Centered Support P~~service plan as necessary.

6. Staffing Requirements

a. Each Alternative Care Facility Provider Agency will divide the 24-hour day into two 12-hour blocks which will be considered daytime and nighttime. The designation of daytime and nighttime hours shall be permanently documented in the Alternative Care Facilities policy and disclosed in the written Member agreements. In determining appropriate staffing levels, the Alternative Care Facility ~~p~~Provider Agency shall adjust staffing ratios based on the individual acuity and needs of the Members in the Alternative Care Facility~~.~~. At a minimum, staffing must be sufficient in number to provide the services described in the service plans~~Person-Centered Support Plans~~, considering the Member's needs, level of assistance, and risks of accidents. A staff person may have multiple functions, as long as they meet the definition of Direct Care Staff at Sections 8.750~~65~~.D.6. Staff counted in the staff-to-Member ratio are those who are trained and able to provide direct services to Members.

b. Staffing at an Alternative Care Facility shall meet the following standards

i. A minimum of 1 staff to 10 Members during the daytime.

ii. A minimum of 1 staff to 16 Members during the nighttime.

iii. A minimum of 1 staff to 6 Members in a Secured Environment at all times.

1) The Alternative Care Facility ~~p~~Provider Agency shall ensure a minimum of one awake staff ~~M~~member that is on duty during all hours of operation in a Secured Environment

c. Staffing Ratio Waiver

i. Staffing waiver requests shall be submitted to the Department's Alternative Care Facility Benefit Administrator. Requests will be evaluated based on several criteria including, but not limited to:

1) The number of years Alternative Care Facility has been in operation;

2) Past Incidents as defined Section at 7.402.10 at the Alternative Care Facility;

3) Whether the Alternative Care Facility Provider Agency has adequately documented how a staffing waiver would not jeopardize the health, safety or quality of life of the Members;

4) Provider availability and Member access; and

5) Whether the Alternative Care Facility ~~p~~Provider Agency has been free of deficiencies impacting Member health and safety in both the Colorado Department of Public Health and Environment (CDPHE) and Life Safety Code survey and inspections.

ii. An approved staffing waiver is only applicable for nighttime hours, with the exception for Secured Environments.

iii. A staffing waiver expires five years from the date of approval. No staffing waiver shall continue after the expiration of five years from the date of approval without approval by the Department.

iv. Any existing staffing waiver may be subject to revocation if an Alternative Care Facility does not comply with any applicable regulations, is cited with deficiencies impacting Member health and safety by the Colorado Department of Public Health and Environment (CDPHE) or the Division of Fire Protection Control, has substantiated patient care Complaints, or the staffing waiver has jeopardized the health, safety or quality of life of the Members.

1) In the event a staffing waiver is denial or revoked, an Alternative Care Facility may reapply for a staffing waiver only after the Alternative Care Facility receives a Colorado Department of Public Health and Environment (CDPHE) and Life Safety survey with no deficiencies impacting Member health and safety

2) Existing staffing waivers shall be null and void upon a change in the total number of licensed beds or a change of ownership in an Alternative Care Facility.

v. The Alternative Care Facility Provider Agency shall ensure that all staff and volunteer training be completed within the first 30 days of employment. Training shall include, but is not limited to, the training topics described in 6 CCR 1011-1, Chapter VII, Section 7.9.

vi. The Provider Agency shall ensure the Administrator and all staff meet the qualifications and employment standards set forth in 6 CCR 1011-1, Chapter VII, Section 7.4.

8.750~~5~~6.G Alternative Care Facility Standards for Secured Environment ~~ACFs~~

1. Alternative Care Facility Provider Agencies providing a secured environment may be licensed for a maximum of 30 secured beds.

a. A waiver may be granted by the Department when adequate documentation of the need for additional beds has been proven and the number of beds would not jeopardize the health, safety and quality of care of Members.

2. The Alternative Care Facility shall establish an environment that promotes independence and minimizes agitation and unsafe wandering through the use of visual cues and signs.

3. Provide a secured outdoor area accessible without staff assistance, which shall be level, well maintained, and appropriately equipped for the population served.

8.750~~56~~.H Appropriateness of Medicaid Participant Placement

1. Alternative Care Facilities must comply with 6 CCR 1011-1 Chapter 7, Part 11 when admitting a Member or providing a 30 days' notice of discharge.

8.750~~56~~.I Alternate Care Facility Provider Agency Reimbursement Requirements

1. Room and board shall not be a benefit of Alternative Care Facility services.

2. Alternative Care Facility services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.

   a. Alternative Care Facility services are subject to Post Eligibility Treatment of Income (PETI), as outlined in Section 8.7202.BB~~8.486.60~~.

3. Non-Medical/Programmatic Leave Reimbursement

   a. The Alternative Care Facility may receive reimbursement for a maximum of 42 days in a calendar year for Non-Medical/Programmatic Leave Days combined.

   b. The Alternative Care Facility shall not be reimbursed for services during Leave Days if the Member is receiving Medicaid services over 24 hours in another approved Medicaid Facility, such as a nursing facility or hospital.

8.750~~67~~ Assistive Technology

8.750~~67~~.A Assistive Technology Eligibility

1. Assistive Technology is a covered service available to Members enrolled in one of the following HCBS waivers:

   a. Brain Injury Waiver

   b. Children's Extensive Supports Waiver

   c. Supported Living Services Waiver

8.750~~67~~.B Assistive Technology Definitions

1. Assistive Technology Device means an item, piece of equipment, or product system, including tablets, software, and phone applications, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of Members.

2. Assistive Technology Service means a service that directly assists a Member in the selection, acquisition, or use of an assistive technology device.

8.750~~67~~.C Assistive Technology Inclusions

1. Assistive Technology is authorized for Organized Health Care Delivery Service (OHCDS) as outlined at Section 8.7202.W.

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

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

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

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

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

   e. Training or technical assistance for the Member, or where appropriate, the Family Members, Guardians, caregivers, advocates, or Legally Authorized Representatives of the Member.

   f. Warranties, repairs, or maintenance on assistive technology devices purchased through the waiver.

   g. Adaptations to computers, or computer software related to the Member's identified needs in their Person-Centered Support Plan.

~~2~~3. HCBS Brain Injury (BI) Waiver

   a. For Members enrolled in the HCBS-BI Waiver, the following are covered Assistive Technology benefits:

      i. Specialized medical equipment and supplies including devices controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform Activities of Daily Living, or to perceive, control, or communicate with the environment in which they live.

      ii. Assistive devices that augment an individual's ability to function at a higher level of independence ~~and lessen the number of direct human service hours required to maintain independence~~.

      iii. Assistive devices that enable the individual to secure help in the event of an emergency or are used to provide reminders to the individual of medical appointments, treatments, or medication schedules.

      iv. Assistive devices to augment cognitive processes, "cognitive-orthotics" or memory prostheses. Examples of cognitive orthotic devices include informational databases, spell checkers, text outlining programs, timing devices, security systems, car finders, sounding devices, cueing watches, electronic medication monitors, and memory communication devices.

v. Training or technical assistance for the Member, or where appropriate, the Family Members, Guardians, caregivers, advocates, or Legally ~~a~~Authorized ~~r~~Representatives of the Member.

vi. Warranties, repairs, or maintenance on assistive technology devices purchased through the waiver.

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

8.750~~76~~.D Assistive Technology Exclusions and Limitations

1. Assistive technology devices and services are only available to meet needs identified through the Person-Centered Support Plan. They shall be the most cost effective and efficient means to meet the identified need and cannot be available through the Medicaid state plan, other HCBS Waiver Services, or third-party ~~resource~~resources.

2. Items which are not of direct medical or remedial benefit to the Member are excluded

3. HCBS Supported Living Services (SLS) Waiver, Children's Extensive (CES) Waiver:

a. When the expected cost exceeds $2,500 per device, the Case Manager shall obtain and maintain three estimates in the case record and the most cost-effective option shall be selected. When it is not possible to obtain three estimates, documentation shall be maintained in the case record the reason for less than three estimates.

b. The following devices and services are specifically excluded under HCBS waivers and not eligible for reimbursement:

i. Purchase, training, or maintenance of service animals,

ii. Computers or cell phones unless prior authorized according to procedure.

iii. Training or adaptation directly related to a school or home educational goal or curriculum for members under 21 years of age.

iv. Internet or broadband access.

~~viii~~. In-home installed video monitoring equipment.

~~i~~vi. Medication reminders.

~~v. Hearing aids.~~

vii. Items considered as typical toys for children.

viii. Items or devices that are generally considered to be experimental.

ix~~viii~~. Items or devices that are used for typical daily activities and are not used to increase, maintain, or improve the functional capabilities of Members. ~~that do meet an identified need through the Person-Centered Support Plan.~~

8.750~~67~~.E Assistive Technology Reimbursement Requirements

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

a. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver without an exception granted by the Department.

b. Costs that exceed this limitation may be approved by the Department for devices to ensure the health and safety of the Member or that enable the Member to function with greater independence in the home~~,~~ or if it decreases the need for paid assistance in another waiver service on a long-term basis.

c. Requests for an exception shall be prior authorized within 30 days of the request in accordance with the Department's procedures.

2. HCBS Brain Injury (BI) Waiver:

a. Reimbursement for assistive devices will be on a per unit basis. If assistive devices are to be used primarily in a vocational application, devices should be funded through the Division of Vocational Rehabilitation with secondary funding from Medicaid.

8.750~~7~~8 Behavioral Programming/Behavioral Management and Education

8.750~~7~~8.A Behavioral Programming/Behavioral Management and Education Eligibility

1. Behavioral Programming/Behavioral Management and Education is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.7~~5~~50~~8~~7.B Behavioral Programming/Behavioral Management and Education Definition

1. Behavioral programming and education means individually developed interventions designed to decrease/control the Member's severe maladaptive behaviors which, if not modified or prevented, will interfere with the Member's ability to remain integrated in the community.

8.750~~8~~7.C Behavioral Programming/Behavioral Management and Education Inclusions

1. Programs should consist of a comprehensive Assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of Family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the Member's environment.

2. Behavioral programs may be provided in the community, or in the Member's residence unless the residence is a Transitional Living Program which provides behavioral intervention as a treatment component.

3. All behavioral programming must be documented in the Member's service plan~~Person-Centered Support Plan~~ and may not exceed 30 units of service. The Department may authorize additional units based on needs identified in the Member's Person-Centered Support Plan or service plan.

8.750~~8~~7.D Behavioral Programming/Behavioral Management and Education Provider Agency Requirements

1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a healthcare professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Master's level

Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of behavioral management concepts.

2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with Brain Injury if their work experience does not include at least one year of the same.

8.750~~7~~8.E Behavioral Programming/Behavioral Management and Education Reimbursement

1. The Case Manager must document the behavioral programming service on the Member's Person-Centered Support Plan and include the number of service units on the Member's Prior Authorization Request (PAR).

2. Behavioral programming services will be ~~paid~~paid for on an hourly basis as established by the Department.

8.750~~8~~9 Behavioral Therapies

8.750~~8~~9.A Behavioral Therapies Eligibility

1. Behavioral Therapies are a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a. Developmental Disabilities Waiver

   b. Supported Living Services Waiver

   c. Brain Injury Waiver

8.750~~8~~9.B Behavioral Therapies Definition

1. Behavioral Therapies mean services related to the Member's intellectual or Developmental Disability that assist a Member to acquire or maintain appropriate interactions with others.

8.750~~9~~8.C Behavioral Therapies Inclusions

1. Behavioral Therapies shall address specific challenging behaviors of the Member and identify specific criteria for remediation of the behaviors.

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

3. Behavioral Therapies include:

   a. Behavioral consultations and recommendations for behavioral interventions and development of behavioral ~~support~~ service plans that are related to the Member's Developmental Disability and are necessary for the Member to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management.

   b. Intervention strategies related to an identified challenging behavioral need of the Member. Specific goals and procedures for the behavioral service shall be established.

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

d. Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:

i. Is related to the Developmental Disability in order for the Member to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

ii. Positively impacts the Member's behavior or functioning, and

iii. May include cognitive behavior therapy, systematic desensitization, anger management, biofeedback, and relaxation therapy.

e. Behavioral line services include direct one on one (1:1) implementation of the behavioral ~~support~~ service plan and are:

i. Delivered under the supervision and oversight of a behavioral consultant.

ii. Inclusive of acute, short-term interventions at the time of enrollment from an institutional setting, or

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

8.750~~8~~9.D Behavioral Therapies Exclusions and Limitations

1. Services covered under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or a covered mental health diagnosis in the Medicaid State Plan, covered by a third-party source or available from a natural support are excluded and shall not be reimbursed.

2. Behavioral consultation services are limited to 80 units per ~~Person-Centered Support Plan~~support plan year. One unit is equal to 15 minutes of service.

3. Behavioral plan Assessment services are limited to 40 units and one ~~A~~assessment per ~~Person-Centered Support~~ support plan year. One unit is equal to 15 minutes of service.

4. Behavioral line services are limited to 960 units per ~~Person-Centered Support Pl~~support plan year. One unit is equal to 15 minutes of service.

5. Counseling services are limited to 208 units per ~~Person-Centered S~~support ~~P~~plan year. One unit is equal to 15 minutes of service.

6. Services for the sole purpose of training basic life skills, such as Activities of Daily Living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

8.7509.E Behavioral Therapies Provider Agency Requirements

1. Behavioral Therapies consultants shall meet one of the following minimum requirements:

a. Shall have a Master's degree or higher in behavioral, social or health sciences or education and be nationally certified as a "Board Certified Behavior Analyst" (BCBA), or

certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities; or

b. Shall have a Baccalaureate degree or higher in behavioral, social or health sciences or education and

i. Be certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or

ii. Be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and be working under the supervision of a certified or licensed Behavioral Services Provider.

2.. Counselors shall meet one of the following minimum requirements:

a. Shall hold the appropriate license or certification for the provider's discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, Licensed Clinical Psychologist, or BCBA and must demonstrate or document a minimum of two years' experience in providing counseling to individuals with intellectual and developmental disabilities; or

b. Have a Baccalaureate degree or higher in behavioral, social or health science or education and work under the supervision of a licensed or certified professional as set forth above in requirement one (1).

3. Behavioral Plan Assessor shall meet one of the following minimum qualifications:

a. Shall have a Master's degree or higher in behavioral, social or health science or education and be nationally certified as a BCBA or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities; or

b. Shall have a Baccalaureate degree or higher in behavioral, social or health science or education and be 1) certified as a "Board Certified Associate Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and working under the supervision of a certified or licensed Behavioral Services provider.

4. Behavioral Line Staff shall meet the following minimum requirements:

a. Must be at least 18 years of age, graduated from high school or earned a high school equivalency degree and have a minimum of 24 hours training, inclusive of practical experience in the implementation of positive behavioral supports and/or applied behavioral analysis and that is consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities. Works under the direction of a Behavioral Consultant.

8.750~~9~~910 Benefits Planning Service

8.750~~9~~910.A Benefits Planning Service Eligibility

1. Benefits Planning Service is available to Members enrolled in one of the following HCBS waivers:
    a. Developmental Disabilities Waiver
    b. Supported Living Services Waiver

8.751009~~0~~9.B Benefits Planning Service Definition

1. Benefits Planning means analysis and guidance provided to a Member and their family/support network to improve their understanding of the potential impact of employment-related income on the Member's public benefits. Public benefits include, but are not limited to Social Security, Medicaid, Medicare, food/nutrition programs, housing assistance, and other federal, state, and local benefits. Benefits Planning gives the Member an opportunity to make an informed choice regarding employment opportunities or career advancement.

8.751009~~0~~9.C Benefits Planning Service Inclusion

1. Benefits Planning is available regardless of employment history or lack thereof and may be accessed throughout the phases of a Member's career such as: when considering employment, changing jobs, or for career advancement/exploration.
2. Certified Benefits Planners support Members by providing any of these core activities:
    a. Intensive individualized benefits counseling;
    b. Benefits verification;
    c. Benefit summary & analysis;
    d. Identifying applicable work incentives, and if needed, developing a work incentive plan for the Member and team;
3. In addition to the core activities, Benefits Planning may also be utilized to:
    a. Conduct an informational meeting with the Member, alone or with their support network.
    b. Assist with evaluating job offers, promotional opportunities (increase in hours/wage), or other job changes that the Member is considering which change~~s~~ income levels; and outlining the impact that change may have on public benefits.
    c. Provide information on Waiver Benefits (including Buy-In options), federal/state/local programs, and other resources that may support the Member in maintaining benefits while pursuing employment.
    d. Assist with referrals and connecting the Member with identified resources, as needed, and coordinating with the Member, Case Manager, family, and other team Members to promote accessing services/resources that will advance the Member's desired employment goals.
    e. Navigate complicated benefit scenarios and offer problem-solving strategies, so the Member may begin or continue working while maintaining eligibility for needed services.

f. Offer suggestions to the Member and their family/support network regarding how to create and maintain a recordkeeping structure and reporting strategy related to benefit eligibility and requirements.

1) If the Member needs assistance with the collection and submission of income statements and/or documentation related to the Social Security Administration (SSA), or other benefits managing organizations, and the Member does not have other supports to do so, the Benefits Planner may assist on a temporary basis.

g. Assist in accessing federal/state/local resources, evaluating the potential impact on benefits due to changes in income, and if there is a negative impact identified, explore alternatives to meet existing needs, all in collaboration with the Member's Case Manager and support team.

8.750109.D Benefits Planning Service Exclusions and Limitations

1. Benefits Planning shall not take the place of, nor shall it duplicate services received through the Division of Vocational Rehabilitation.

2. Benefits Planning services are limited to 40 units per ~~service~~ support plan year. One unit is equal to 15 minutes of service.

8.750109.E Benefits Planning Service Provider Agency Requirements

1. Benefits Planning may be provided only by Certified Benefits Planners. A Certified Benefits Planner holds at least one of the following credentials:

   a. Community Work Incentives Coordinator (CWIC);

   b. Community Partner Work Incentives Counselor (CPWIC);

   c. Credentialed Work Incentives Practitioner (WIP-CTM).

2. Documentation of the Benefits Planner's Certification and additional trainings shall be maintained and provided upon request by a surveyor or the Department.

3. Certified Benefits Planners must obtain and sustain a working knowledge of Colorado's Medicaid Waiver system as well as federal, state, and local benefits.

4. The Benefits Planning provider must maintain records which reflect the Benefits Planning activities that were completed for the Member, including copies of any reports provided to the Member.

5. If the Certified Benefits Planner encounters a benefit situation that is beyond their expertise, consultation with technical assistance liaisons is expected.

8.75110Bereavement Counseling

8.75110.A Bereavement Counseling Eligibility

1. Bereavement Counseling is a covered benefit available to Members enrolled in the HCBS Children's with Life Limiting Illness Waiver.

8.75110.B Bereavement Counseling Definition

1. Bereavement Counseling means counseling provided to the Member and/or Family Members to guide and help them cope with the Member's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition.

8.7511~~0~~.C Bereavement Counseling Exclusions and Limitations

1. Bereavement Counseling shall be a benefit only if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or from other sources.

8.7511.D Bereavement Counseling Provider Agency Requirements

1. Bereavement Counseling shall only be provided by individuals licensed or certified in at least one of the following credentials:

    a. Licensed Clinical Social Worker (LCSW)

    b. Licensed Professional Counselor (LPC)

    c. Licensed Social Worker (LSW)

    d. Licensed Independent Social Worker (LISW)

    e. Licensed Psychologist; or

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

2. Providers shall be licensed, good standing, with their specific specialty practice act or with current state licensure regulations.

3. Individuals providing Bereavement Counseling shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

8.7511~~0~~.E~~D~~ Bereavement Counseling Reimbursement

1. Bereavement Counseling may be initiated and reimbursed while the Member is on the CLLI waiver but may continue for one year following the death of the Member.

8.7512~~1~~ Child and Youth Mentorship

8.7512~~1~~.A Child and Youth Mentorship Eligibility

1. Child and Youth Mentorship is a covered benefit available to Members enrolled in the HCBS Children's Habilitation Residential Program Waiver.

8.7512~~1~~.B Child and Youth Mentorship Definition

1. Child and Youth Mentorship means the implementation of therapeutic and/or behavioral service and support plans, building life skills, providing guidance to the child or youth with self-care, learning self-advocacy, and protective oversight as defined at Section 8.750~~5~~6.B.2.

8.7512~~1~~.C Child and Youth Mentorship Inclusions

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

2. Service may be provided in the Member's home or community as determined by the Wraparound Plan.

3. Child and Youth Mentorship may be provided individually, or in conjunction with the Wraparound Service, defined at Section 8.75574.

8.75121.D Child and Youth Mentorship Provider Agency Requirements

1. Individuals providing Child and Youth Mentorship must meet the following criteria:

    a. Complete at least 40 hours of training in Crisis Prevention, De-escalation, and Intervention that must encompass all of the following:

        i. Trauma informed care.

        ii. Youth mental health first aid.

        iii. Positive Behavior Supports, behavior intervention, and de-escalation techniques.

        iv. Cultural competency.

        v. Family systems and Family engagement.

        vi. Child and adolescent development.

        vii. Mental health topics and services.

        viii. Substance abuse topics and services.

        ix. Psychotropic medications.

        x. Prevention, detection, and reporting of mistreatment. abuse, neglect, and exploitation.

        xi. Intellectual and Developmental Disabilities.

        xii. Child/youth specific training.

    b. Complete annual refresher courses on the above training topics.

8.75132 Chiropractic

8.75132.A Chiropractic Eligibility

1. Chiropractic is a covered benefit available to Members enrolled in the HCBS Complementary and Integrative Health Waiver.

8.75132.B Chiropractic Definition

1. Chiropractic means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting and/or improving alignment, neurological function, and other musculoskeletal problems. During a chiropractic treatment, nutrition, exercise, and rehabilitative therapies may be recommended in support of the adjustment.

8.75132.C Chiropractic Inclusions

1. Chiropractic may be utilized to treat conditions or symptoms related to the Member's qualifying condition and Inability to Independently Ambulate.

2. Members receiving Chiropractic services, or other complementary and integrative health services shall be asked to participate in an independent evaluation to determine the effectiveness of the services.

3. Chiropractic shall be provided in the office or clinic of a licensed chiropractor, an approved outpatient setting, or in the Member's residence.

8.751~~2~~3.D Chiropractic Exclusions and Limitations

1. Chiropractic shall be limited to the Member's assessed need for services as identified and documented in the Person-Centered Support Plan.

2. A maximum of 408 combined units of Acupuncture, Chiropractic, and Massage Therapy Waiver Services may be covered as a benefit during the ~~Person-Centered Support Plan~~support plan year.

8.751~~3~~2.E Chiropractic Service Provider Agency Requirements

1. Chiropractors shall be licensed by the State Board of Chiropractic pursuant to § 12-215-101 et seq (C.R.S.) and have at least one year experience practicing Chiropractic at a rate of 520 hours per year; OR one year of experience working with individuals with paralysis or other long term physical disabilities.

2. Chiropractic Provider Agencies shall:

    a. Determine the appropriate modality, amount, scope, and duration of chiropractic service within the established limits described at Section 8.751~~2~~3.D.2.

    b. Recommend only services that are necessary and appropriate in a recommendation plan of care that the Provider Agency will submit to the Member's Case Manager.

    c. Provide only services in accordance with the Member's prior authorized units.

8.751~~3~~4 Community Connector Services

8.751~~4~~3.A Community Connector Services Eligibility

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

    a. Children's Extensive Support Waiver

    b. Children's Habilitation Residential Program Waiver

8.751~~4~~3.B Community Connector Services Inclusions

1. Community Connector services shall the Member in integrating into the Member's community and access naturally occurring resources. Community Connector services shall:

    a. Support the abilities and skills necessary to enable the Member to access typical activities and functions of community life such as those chosen by the general population.

b. Utilize the community as a learning environment to assist the Member to build relationships and natural supports in the Member's residential community.

c. Be provided one-on-one, to a single Member, in a variety of settings within the community in which Members interact with individuals without disabilities other than the individual who is providing the service to the Member.

d. The targeted behaviors, measurable goal(s), and plan to address those behaviors must be clearly articulated in a service plan~~the Person-Centered Support Plan~~.

8.75143.C Community Connector Services Exclusions and Limitations

1. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets, or any activity that is entertainment in nature or any food or drink items are specifically excluded and shall not be reimbursed.

2. Telehealth Community Connector services cannot be provided by the member's legally responsible person/s.

3. HCBS-CHRP Waiver - This service is limited to 2080 units per ~~Person-Centered S~~support ~~P~~plan year. This unit limit applies to Community Connector services provided by either a legally responsible person(s) or another service provider.

   a. A request to increase service hours may be made to the Department on a case-by-case basis.

4. HCBS-CES Waiver - This service is limited to 2080 units per ~~Person-Centered S~~support ~~P~~plan year when the service is provided by a legally responsible person(s). There is not a unit limit when the service is provided by another service provider.

5. A request to increase service hours provided by the ~~m~~Member's legally responsible person(s) may be made to the Department on a case-by-case basis.

8.75154 Consumer Directed Attendant Support Services (CDASS)

8.75154.A CDASS Eligibility

1. CDASS is a covered benefit available to Members enrolled in 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

8.75154.B CDASS Definitions pertaining to Section 8.7515

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

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 8.75145.I who provides CDASS as described in Section 8.75154.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 8.75154.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 8.75145.G and 8.75145.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 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 ~~Person-Centered S~~support ~~P~~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.

10. 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 ~~this rule~~Ssection 8.001.

11. 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.

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

13. Financial Eligibility means the Health First Colorado Financial Eligibility criteria based on Member income and resources.

14. 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.

15. 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.

16. 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.

17. 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.

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

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

8.75154.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 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.

   e. Provide a statement, at an interval determined by the Department, 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.

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

      i. Member training obligations

         1) Members and ARs who have received training through the Training and Support Contractor in the past two years or utilized CDASS in the previous six months may receive a modified training 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 if they received CDASS in the previous six months.

8.75154.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 8.75267.

   b. Personal Care services as described at Section 8.75368.

   c. Health Maintenance Activities services as described at Section 8.75232.

8.75154.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 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.

8.75154.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 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 and retraining 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 8.75145.G; 8.75223.C; 8.75286.C; and 8.75368.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.

8.75154.G CDASS Member/AR Responsibilities

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

   a. Complete training provided by the Training and Support Contractor. Members who cannot complete training 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 8.75154.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.

8.75154.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 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 8.751<u>5</u>4.G.

8.751<u>5</u>4.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 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.

   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 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 based on their personal assistance needs. Attendants may not be present during the budgeting portion of the training.

8.751<u>5</u>4.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.

2. In addition to the requirements set forth at Section 8.75154.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 (2023). 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 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.75154.K CDASS Selection of Financial Management Services (FMS) Contractor

1. The Member/Authorized Representative (AR) shall select an FMS Contractor from the Contractor 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 the selected FMS Contractor until the transition to the new FMS Contractor is completed.

8.75154.L CDASS Start of Services

1. The CDASS start date shall not occur until all of the requirements contained in Sections 8.75154.C, 8.75154.F, 8.75154.G, 8.75154.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.

8.75154.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, homemaker 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. 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 modified to ensure no duplication of services.

8.75154.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 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, 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 8.75154.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.

8.75154.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 8.75154.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.

   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, appoint an AR, or remediate CDASS management per Section 8.75154.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.

8.75154.P Ending The 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 8.751<u>5</u>4.O.1.b, 8.751<u>5</u>4.O.1.d, 8.751<u>5</u>4.O.1.e, 8.751<u>5</u>4.O.1.f, and 8.751<u>5</u>4.O.1.g may not be re-enrolled in CDASS as a service delivery option.

4. Members who are involuntary terminated pursuant to Section 8.751<u>5</u>4.O.1.a are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at 8.751<u>5</u>4.C.1.e. The Member or AR must have successfully completed CDASS training prior to enrollment in CDASS.

5. Members who are involuntary terminated pursuant to 8.751<u>5</u>4.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 prior to enrollment in CDASS.

6. Members who are involuntarily terminated pursuant to 8.751<u>5</u>4.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 prior to enrollment in CDASS.

8.751<u>5</u>4.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 utilization management review process and receive prior authorization before authorizing a start date for Attendant services for Person-Centered Support Plan that;

i. Contain Health Maintenance Activities; or

ii. Service Accommodation requests.

~~d. Allocations that exceed the Service Accommodation request threshold cannot be authorized by the Case Manager without Department approval.~~

~~e. Allocations that include Health Maintenance Activities cannot be authorized by the Case Manager without Department approval. The Case Manager will follow the Department's utilization management review process and receive authorization prior to authorizing a start date for Attendant services.~~

4. Prior to training 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 CDASS Task Worksheet and 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 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, 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. 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.

8.75154.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 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.

8.75154.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.

      ii. 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.

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

8.75165 Counseling Services

8.75165.A Counseling Services Eligibility

1. Counseling Services is a service available to Members enrolled in the HCBS Brain Injury Waiver.

8.75165.B Counseling Services Definition

1. Counseling services mean individualized services designed to assist Members and their support systems to more effectively manage stress related situations due to a Brain Injury diagnosis.

8.75165.C Counseling Services Inclusions

1. Counseling is available to the Member's Family and support network in conjunction with the Member if they: a) have a significant role in supporting the Member or b) live with or provide care to the Member. "Family" and "support network" includes a Parent, spouse, child, relative, foster family, in-laws, or other person who may have significant ongoing interaction with the Member.

2. Services may be provided in the Member's residence, in community settings, or in the provider's office.

3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.

4. The need for ~~A~~all ~~c~~Counseling ~~s~~Services must be documented in the Person-Centered Support Plan.

5. All Counseling Services ~~and~~ must be provided by ~~individuals or a~~enrolled HCBS Provider Agencies ~~approved as providers of Waiver Services by the Department~~.

~~5~~6. Family training/counseling must be carried out for the direct benefit of the Members of the HCBS-Brain Injury program.

6. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the ~~Person-Centered Support Plan~~service plan and shall include updates as may be necessary to safely maintain the Member at home.

7. The service is limited to thirty 30 visits of individual, group, family, or a combination of counseling services. The Department may authorize additional units based on needs identified in the Person-Centered Support Plan or service plan.

8.75165.D Counseling Services Exclusions and Limitations

1. Family training is not available to individuals who are employed to care for the Member.

8.75165.E Counseling Services Provider Agency Requirements

1. Professionals providing ~~c~~Counseling ~~s~~Services must hold the appropriate license or certification for their discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, or Licensed Clinical Psychologist. Master's or doctoral level counselors who meet experiential and educational requirements but lack the certification or credentialing as described above, may submit their professional qualifications via curriculum vitae or resume for consideration.

2. All professionals applying as ~~p~~Provider Agencies of ~~c~~Counseling ~~s~~Services must demonstrate or document a minimum of two years of experience in providing counseling to Members with a Brain Injury and their families.

8.75165.F Counseling Services Reimbursement

1. Reimbursement will be on an hourly basis per type of counseling service as established by the Department. There are three distinct counseling services allowable under Brain Injury ~~c~~Counseling ~~s~~Services including Family Counseling, Individual Counseling, and Group Counseling.

8.75176 Day Habilitation

8.75176.A Day Habilitation Eligibility

1. Day Habilitation is a covered benefit for Members enrolled in one of the following HCBS waivers:
    a. Developmental Disabilities Waiver
    b. Supported Living Services Waiver

8.75176.B Day Habilitation Inclusions

1. Day Habilitation shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the Member's private residence or other residential living arrangement.
2. Day Habilitation services and supports encompass three (3) types of habilitative services; Specialized Habilitation Services, Supported Community Connections, and Prevocational Services.
    a. Specialized Habilitation (SH) services are community-integrated services provided out of a non-residential setting, provided to enable the Member to attain the maximum functional level or to be supported in such a manner that allows the Member to gain an increased level of self-sufficiency. Specialized Habilitation services:
        i. Include the opportunity for Members to select from Age-Appropriate Activities and Materials, as defined in Section 8.7001.A.1 both within and outside of the setting;
        ii. Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, and maintenance skills; and
        iii. May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the Person-Centered Support Plan.
    b. Supported Community Connections (SCC) services are provided to support the abilities and skills necessary to enable the Member to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement, and volunteer activities. SCC services:
        i. Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a Member's service plan or Person-Centered Support Plan;
        ii. Are conducted in a variety of settings in which the Member interacts with persons without disabilities other than those individuals who are providing services to the

Member. These types of services may include socialization, adaptive skills and personnel to accompany and support the Member in community settings;

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

iv. May be provided in a group setting or on a one-to-one (1:1) basis as identified in the service plan~~Person-Centered Support Plan~~.

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

c. Prevocational services must comply with Supported Employment regulations at Section 8.754~~6~~9.

d. Telehealth Day Habilitation services

i. Telehealth Specialized Habilitation services includes provider-hosted virtual meetings, groups, and activities where Members virtually engage and interact with ~~p~~Provider Agency staff, volunteers, and other Members.

ii. Telehealth Supported Community Connections services includes virtual meetings, groups and activities, that are hosted by non-provider entities where Members virtually engage and interact with persons without disabilities other than those individuals who are providing services to the Member.

8.7517~~6~~.C Day Habilitation Exclusions and Limitations

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

2. Day Habilitation services may not be delivered virtually 100% of the time.

a. Specialized Habilitation ~~p~~Provider Agencies must maintain a physical location where in-person services are offered.

b. There will always be an option for in-person Day Habilitation services available.

8.7517~~6~~.D Day Habilitation Provider Agency Requirements

1. Provider Agencies shall maintain documentation that includes the date and start/end times of activities completed, what activities were completed, and what Person-Centered Support Plan goals of the Member are being achieved through the activity(ies).

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

3. If the Provider Agency provides services in the community to persons who may visit the offices of the Provider Agency (or another service operated facility), but the persons receive services at such location(s) for less than one hour per visit, requirements of Sections 8.7412.A.1-4 do not apply. The Provider Agency shall, however, ensure that the facility complies with the ADA and contains no hazards which could jeopardize the health or safety of persons visiting the site.

4. For physical facilities used as community integrated sites over which the Provider Agency exercises little or no control, the Provider Agency shall:

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

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

5. Specialized Habilitation Services Provider Setting

   a. Specialized Habilitation settings must meet the criteria outlined in Section 8.7001.B.

   b. The Specialized Habilitation location shall provide a clean and sanitary environment that is physically accessible to the Members, including those Members with supportive devices for ambulation or who are in wheelchairs.

   c. The Specialized Habilitation location shall provide age-appropriate activities appropriate to the number and needs of the Members, at the times desired by the Members.

8.7517~~6~~.E Day Habilitation Provider Agency Reimbursement Requirements

1. Supported Living Services Waiver:

   a. Day habilitation services, in combination with prevocational services and supported employment, are limited to seven thousand one hundred and twelve (7,112) units per ~~Person-Centered Support Plan~~support plan year. One (1) unit is equal to fifteen (15) minutes of service.

2. Developmental Disabilities Waiver:

   a. Day Habilitation services, in combination with Prevocational services, are limited to four thousand eight hundred (4,800) units. When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and

   b. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One (1) unit is equal to fifteen (15) minutes of service.

3. DD & SLS: Day Habilitation services have 3 tiers for service provision:

   a. Tier 1 - Specialized Habilitation and Supported Community Connections services are provided virtually via Telehealth. Tier 1 services should be billed at the Tier 2 rate, according to the Member's Support Level.

   b. Tier 2 - Traditional Specialized Habilitation and Supported Community Connections services provided in a group setting, apart from the Member's residence, and billed for at the Tier 2 rate, according to the Member's Support Level. Tier 2 Supported Community Connections services may also be provided to a single Member, utilizing the community as the learning environment. Tier 2 services are delivered in-person.

   c. Tier 3 - Supported Community Connections services.

i. SCC services are provided 1:1, to a single Member, and billed for at the Tier 3 Supported Community Connections rate. Members who receive Supported Community Connections services under Tier 3 are also required to stay within the Member's individual annual dollar limit for the combination of group and 1:1 Day Habilitation services. Tier 3 services must be delivered in-person.

1) One-on-one Supported Community Connections services may be billed for at the individualized rate and when this occurs the combination of group and 1:1 Day Habilitation services are required to stay within the Member's individual annual dollar limit, as well as the unit limit. Members who have an exceptional need to exceed one's individualized annual dollar limit may request additional funding through the Department's exception process.

8.7518~~7~~ Day Treatment

8.7518~~7~~.A Day Treatment Eligibility

1. Day Treatment is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.7518~~7~~.B Day Treatment Definition

1. Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the Member lives.

8.7518~~7~~.C Day Treatment Inclusions

1. Day Treatment includes the following components:

   a. Social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management).

   b. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, Case Management~~,~~ and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan.

2. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statute.

3. The provider shall coordinate with other community-based resources and providers.

   a. Counseling and Referrals to appropriate professionals when Crisis situations occur with the Member and Family or staff.

   b. Behavioral programming which contains specific guidelines on treatment parameters and methods.

4. Transportation between therapeutic tasks in the community shall be included in the rate for day treatment.

8.75187.D Day Treatment Provider Agency Requirements

1. Directors of day treatment programs shall have professional licensure in a health-related program in combination with at least 2 years of experience in head trauma rehabilitation programming.

2. Providers are required to have regular contact and meetings with the Members and their families to discuss ~~Person-Centered Support Plan~~service plan progress and revision.

8.75187.E Day Treatment Provider Reimbursement Requirements

1. Day treatment services will be paid on a per diem basis at a rate to be determined by the Department. In order for a ~~p~~Provider Agency to be paid for a day of treatment, a Member must have attended and received day treatment services for a minimum of 2 hours per day.

8.75198 Dental

8.75198.A Dental Eligibility

1. Dental is available to Members enrolled in one of the following HCBS waivers:

   a. Developmental Disabilities Waiver

   b. Supported Living Services Waiver

8.75198.B Dental Definition

1. Dental care means services administered for diagnostic and preventative care to abate tooth decay, and medically appropriate treatments to restore dental health.

8.75198.C Dental Inclusions

1. Preventative services include:

   a. Dental insurance premiums, copayments/and coinsurance;

   b. Periodic examination and diagnosis;

   c. Radiographs when indicated;

   d. Non-intravenous sedation;

   e. Basic and deep cleanings;

   f. Mouth guards;

   g. Topical fluoride treatment; and

   h. Retention or recovery of space between teeth when indicated

2. Basic services include:

   a. Fillings;

   b. Root canals;

   c. Denture realigning or repairs;

d. Repairs/re-cementing crowns and bridges;

e. Non-emergency extractions including simple, surgical, full and partial;

f. Treatment of injuries; or

g. Restoration or recovery of decayed or fractured teeth.

3. Major services include:

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

b. Crowns.

c. Bridges.

d. Dentures.

8.75198.D Dental Exclusions and Limitations

1. Dental services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined at Section 8.076.1.8, or available through a third party. General limitations to dental services including frequency will follow the Department's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the Member.

2. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior authorization by the Administrative Service Organization.

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

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

5. Full mouth implants or crowns are not covered.

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

a. Elimination of fractures of the jaw or face,

b. Elimination or treatment of major handicapping malocclusion, or

c. Congenital disfiguring oral deformities.

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

8. Preventative and basic services are limited to $2,000 per ~~Person-Centered Support Plan~~ support plan year. Major services are limited to $10,000 for the five year renewal period of the waiver.

8.752019 Electronic Monitoring

8.752019.A Electronic Monitoring Eligibility

1. Electronic Monitoring is a covered benefit available to Members enrolled in 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

8.752019.B Electronic Monitoring Definitions

1. Electronic ~~m~~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 ~~m~~Monitoring ~~p~~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 8.752019.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.

8.752019.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 8.752019.D.

8.752019.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 an HCBS benefit if the service or device is available 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.

8.752019.E Electronic Monitoring Provider Agency Requirements

1. Electronic ~~m~~Monitoring ~~p~~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 ~~p~~Provider Agency of ~~e~~Electronic ~~m~~Monitoring shall train the Member in the use of the device.

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

8.752019.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 under this Section for Electronic Monitoring in Provider-owned, -Controlled, or Congregate Facilities.

8.75210 Expressive Therapy- Art, Music, Play Therapy

8.75210.A Expressive Therapy Eligibility

1. Expressive Therapy is a covered benefit available to Members enrolled in the HCBS Children's with Life Limiting Illness Waiver.

8.75210.B Expressive Therapy Definition

1. Expressive Therapy means creative art, music or play therapy which provides Members the ability to express their medical situation creatively and kinesthetically for the purpose of allowing the Member to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

8.75210.C Expressive Therapy Inclusions

1. Expressive Therapy may be provided in an individual or group setting.

8.75210.D Expressive Therapy Exclusions and Limitations

1. Expressive Therapy is limited to the Member's assessed need up to a maximum of 39 hours per annual ~~Person-Centered Support Plan~~support plan year.

8.75210.E Expressive Therapy Provider Agency Requirements

1. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a ~~qualified~~ Medicaid enrolled home health or hospice Agency.

   a. Individuals providing Expressive Therapy delivering art or play therapy services shall meet the requirements for individuals providing Therapeutic Life Limiting Illness Support services and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent Members.

   b. Individuals providing Expressive Therapy delivering music therapy services shall hold a Bachelor's, Master's or Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists, and have at least one year of experience in the provision of music therapy to pediatric/adolescent Members.

8.75224 CHRP Habilitation

8.75224.A CHRP Habilitation Eligibility

1. CHRP Habilitation is a covered benefit available to Members enrolled in the HCBS Children's Habilitation Residential Program Waiver

8.75224.B CHRP Habilitation Inclusions

1. CHRP Habilitation is a 24 hour service that includes assisting a Member in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in Home and Community-Based settings. Service components include the following:

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

b. Self-advocacy training and support which may include assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing Abuse, Neglect, Mistreatment, and/or Exploitation of self, responsibility for one's own actions, and participation in meetings.

2. Cognitive services which include assistance with additional concepts and materials to enhance communication. Cognitive Services are intended to help the Member better understand cause and effect and the connection between behaviors and consequences. Services may also include training in repetitive directions, staying on task, levels of receptive language capabilities, and retention of information.

3. Emergency assistance which includes safety planning, fire and disaster drills, and Crisis intervention.

4. Community ~~a~~Access ~~s~~Supports ~~which~~ includes assistance developing the abilities and skills necessary to enable the Member to access typical activities and functions of community life such as education, training, and volunteer activities. Community access supports includes providing a wide variety of opportunities to develop socially appropriate behaviors, facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in Member's Person-Centered Support Plan or service plan. These activities are conducted in a variety of settings in which the Member interacts with non-disabled individuals (other than those individuals who are providing services to the Member). These services may include socialization, adaptive skills, and personnel to accompany and support the Member in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement and are based on the interest of the Member.

5. Transportation services are encompassed within Habilitation and are not duplicative of the non-emergent medical transportation that is authorized in the Medicaid State Plan. Transportation services facilitate Member access to activities and functions of community life.

6. Follow-up counseling, behavioral, or other therapeutic interventions, and physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

7. Medical and health care services that are integral to meeting the daily needs of the Member and include such tasks as routine administration of medications or providing support when the Member is ill.

8.7522~~1~~.C CHRP Habilitation Service Requirements

1. Services may be provided to Members who require additional care for the Member to remain safely in Home and Community-Based settings. The Member must demonstrate the need for such services above and beyond those of a typical child of the same age.

2. Habilitation services under the CHRP waiver differ in scope, nature, supervision, and/or ~~p~~Provider Agency type (including provider training requirements and qualifications) from any other services in the Medicaid State Plan.

3. Habilitation may be provided in a Foster Care Home or Kinship Foster Care Home certified by a licensed Child Placement Agency or County Department of Human Services, Specialized Group Facility licensed by the Colorado Department of Human Services, or Residential Child Care Facility licensed by the Colorado Department of Human Services.

4. Habilitation may be provided for Members aged eighteen (18) to twenty (20) in a Host Home. The Host Home must meet all requirements as defined in Sections 8.754139 Residential Habilitation Services and Supports (RHSS) and 8.754240 Individual Residential Service and Supports (IRSS).

5. Provider Agencies and child placement agencies must comply with the habilitation capacity limits at 12 CCR 2505-8 Section 7.406.2.M.

8.75221.D CHRP Habilitation Provider Agency Requirements

1. The Service Provider Agency or child placement Aagency shall ensure choice is provided to all Members in their living arrangement.

2. The Foster Care Home or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all Members living in the home.

3. The Service Provider Agency shall provide the Case Management Agency a copy of the Foster Care Home or Kinship Foster Care Home certification before any child or youth may be placed in that home. If emergency placement is needed outside of business hours, the Provider Agency or child placement Agency shall provide the Case Management Agency a copy of the Foster Care Home or Kinship Foster Care Home certification the next business day.

4. Provider Agencies for habilitation services and services provided outside the Family home shall meet all of the certification, licensing, waiver, and quality assurance regulations related to their provider type.

8.75221.E CHRP Habilitation Reimbursement

1. A Support Need Level Assessment must be completed upon determination of eligibility. The Support Need Level Assessment is used to determine the level of reimbursement for Habilitation services.

2. Reimbursement for Habilitation service does not include the cost of normal facility maintenance, upkeep, and improvement. This exclusion does not include costs for modifications or adaptations required to assure the health and safety of the Member or to meet the requirements of the applicable life safety code.

3. Room and board shall not be a benefit of habilitation services. Members shall be responsible for room and board, per Section 8.7413.

8.75232 Health Maintenance Activities Self-Directed

8.75232.A Health Maintenance Activities Eligibility

1. Health Maintenance is available to Members eligible for Consumer Directed Attendant Support Services (CDASS) 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

8.75232.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.

8.75232.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.

i. 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.

8.75243 Hippotherapy

8.75243.A Hippotherapy Eligibility

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

a. Children's Extensive Support Waiver

b. Children's Habilitation Residential Program Waiver

c. Supported Living Services Waiver

8.75243.B Hippotherapy Definition

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

8.75243.C Hippotherapy Inclusions

1. Hippotherapy is included when it meets an identified need in the Person-Centered Support Plan.

8.75243.D Hippotherapy Exclusions and Limitations

1. HCBS Children's Extensive Services (CES) Waiver; HCBS Supportive Living Services (SLS); HCBS Children's Habilitation Residential Program (CHRP) Waiver:

a. The following items are excluded under the HCBS waivers and are not eligible for reimbursement:

i. Equine therapy;

ii. Experimental treatments or therapies; and,

iii. Therapeutic Riding.

b. Hippotherapy is not covered as a waiver service if it is available under the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), or from a Third-Party Resource.

8.75243.E Hippotherapy Service Provider Agency Requirements

1. Hippotherapy must be recommended or prescribed by a licensed physician or therapist.

2. The recommendation must clearly identify the need for hippotherapy, a recommended treatment protocol, and expected outcome.

3. The Provider Agency shall be licensed, certified, registered or accredited by an appropriate national accreditation association in the profession.

8.75254 Home Accessibility Modifications and Adaptations

8.75254.A Home Accessibility Modifications and Adaptations Eligibility

1. Home Accessibility Modifications and Adaptations is a covered benefit available to Members enrolled in one of the following HCBS waivers:

a. Brain Injury Waiver

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

8.75254.B Home Accessibility Modifications and Adaptations Definitions

1. The Division of Housing (DOH) is a State entity within the Department of Local Affairs that is responsible for approving Home Modification requests oversight on the quality of Home Modification projects, and inspecting Home Modification projects, as described in

2. Eligible Member means a Member who is enrolled in the following Home and Community-Based Services waivers: Brain Injury, Complementary and Integrative Health, Community Mental Health Supports, or Elderly, Blind and Disabled, Supported Living Services (SLS) and Children's Extensive Supports (CES).

3. Home Modification means specific modifications, adaptations or improvements in an eligible Member's existing home setting which, based on the Member's medical condition:

a. Are necessary to ensure the health, welfare and safety of the Member and

b. Enable the Member to function with greater independence in the home, and

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

d. Prevents institutionalization or supports the deinstitutionalization of the Member.

8.75254.C Home Accessibility Modifications and Adaptations Inclusions

1. Home Modifications, adaptations, or improvements may include but are not limited to the following:

   a. Installing or building ramps.

   b. Installing grab-bars and installing other Durable Medical Equipment (DME) items if such installation shall not be performed by a DME supplier.

   c. Widening doorways.

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

   e. Modifying kitchen facilities.

   f. Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies.

   g. Installing stair lifts or vertical platform lifts.

   h. Modifying an existing second exit or egress window for emergency purposes.

      i. The modification of a second exit or egress window must be approved by the Department, or its agent as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare of the Member.

2. Previously completed home modifications, regardless of original funding source, shall be eligible for maintenance or repair within the remaining balance of the Member's lifetime cap for home modifications while remaining subject to Section 8.75254.C.

   a. There shall be a lifetime cap as determined by the Department per Member. The Department may authorize funds in excess of the Member's lifetime cap if there is:

      i. An immediate risk of the Member being institutionalized; or

      ii. A significant change in the Member's needs since a previous home modification.

3. HCBS Supported Living Services (SLS) and Children's Extensive Services (CES) Waivers:

   a. The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed the cap determined by the Department per Member.

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

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

ii. Either:

1) There is an immediate risk to the Member's health or safety, or

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

8.75254.D Home Accessibility Modifications and Adaptations Exclusions and Limitations

1. Home Modifications must be a direct benefit to the Member and not for the benefit or convenience of caregivers or other residents of the home.

2. Duplicate adaptations, improvements, or modifications are not a benefit. This includes, but is not limited to, multiple bathrooms within the same home.

3. Adaptations, improvements, or modifications as a part of new construction costs are not a benefit.

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

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

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

      ii. configure a bathroom to accommodate a wheelchair.

   c. Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department procedures.

4. The purchase of items available through Durable Medical Equipment (DME) is not a benefit.

5. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

   a. Roof repair,

   b. Central air conditioning,

   c. Air duct cleaning,

   d. Whole house humidifiers,

   e. Whole house air purifiers,

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

   g. Monthly or ongoing home security monitoring fees,

   h. Home furnishings of any type,

   i. HOA fees,

   j. Walk-In Tubs.

k. Adaptations or improvements to the home that are considered to be on-going home repair or maintenance and are not related to the Member's ability and needs are prohibited.

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

6. The Department may deny requests for Home Modification projects that exceed usual and customary charges or do not meet local building requirements, the Long-Term Services and Supports Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards.

7. Home Modification projects are prohibited in any Provider -Owned or -Controlled setting.

8. Volunteer work on a Home Modification project approved by the Department shall be completed under the supervision of the Home Modification Provider Agency as stated on the bid.

a. Volunteer work performed by Department-approved organizations must be described according to Department prescribed processes and procedures. A list of these organizations may be found on the Department website.

b. Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or Family Member, or work performed by a private Contractor hired by the Member or family, must be described and agreed upon, in writing, by the ~~p~~Provider Agency responsible for completing the home modification, according to Department prescribed processes and procedures and must be approved by the Department.

9. If a Member lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by the Fair Housing Act, the Member's Home Modification funds may not be used unless reasonable accommodations have been denied. The Fair Housing Act (42 U.S.C. § 3601, et seq.)(1995) is hereby incorporated by reference. The incorporation of this Act excludes later amendments to, or editions of, the referenced material. Pursuant to §24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.7525~~3~~4.E Home Accessibility Modifications and Adaptations Case Management Agency Responsibilities

1. The Case Manager shall consider alternative funding sources to complete the Home Modification. These alternatives and the reason they are not available shall be documented in the case record.

a. The Case Manager must confirm that the Member is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by the Fair Housing Act.

2. The Case Manager may approve Home Modification projects estimated at less than $2,500 without Department approval, contingent on Member authorization and confirmation of Home Modification fund availability.

3. The Case Manager shall obtain prior approval by submitting a prior request to the Department for Home Modification projects estimated to cost over $2500.

    a. The Case Manager must submit the request and all supporting documentation according to Department prescribed processes and procedures. Home Modification requests submitted with improper documentation cannot be authorized.

    b. The Case Manager and Case Management Agency are responsible for retaining and tracking all documentation related to a Member's previous home modification benefit lifetime use and communicating that information to the Member and ~~p~~Provider Agencies. The Case Manager may request confirmation of a Member's home modification use from the Department, its fiscal agent, or Division of Housing.

4. Home Modifications estimated to cost $2,500 or more shall be evaluated according to the following procedures:

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

    b. The evaluation services may be provided by a home health Agency or other qualified and approved OT/PT through Medicaid Home Health consistent with Home Health rules set forth in Section 8.520, including physician orders and plans of care.

        i. A Case Manager may initiate the OT/PT evaluation process before the Member has been approved for Waiver Services, as long as the Member is Medicaid Eligible.

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

    c. The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Member's needs.

5. The Case Manager shall solicit bids according to the following procedures:

    a. The Case Manager shall solicit bids from at least two Home Modification Provider Agencies.

        i. The Case Manager must verify that the provider is an enrolled Home Modification Provider Agency.

        ii. The bids must be submitted according to Department prescribed processes and procedures.

    b. The bids shall include a breakdown of the costs of the project including:

        i. Description of the work to be completed.

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

iii. Estimate for building permits, if needed.

iv. Estimated timeline for completing the project.

v. Name, address and telephone number of the Home Modification Provider Agency.

vi. Signature, including option for digital signature, of the Home Modification Provider Agency.

vii. Signature, including option for digital signature, of the Member or Guardian or other indication of approval.

viii. Signature, including option for digital signature, of the homeowner or property manager if applicable.

c. Home Modification Provider Agencies have a maximum of 30 days to submit a bid for the Home Modification project after the Case Manager has solicited the bid.

i. If the Case Manager has made three attempts to obtain a written bid from a Home Modification Provider Agency and the Home Modification Provider Agency has not responded within 30 calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the Home Modification request.

d. The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation to the Department or its agent. The Department or its agent shall authorize the lowest bid that complies with the requirements of Section 8.75254 and the recommendations of the OT/PT evaluation.

i. If a Member or homeowner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the Home Modification request.

e. A revised bid and Change Order request shall be submitted according to the procedures described in this section for any changes from the original approved Prior Authorization Request (PAR) according to Department prescribed processes and procedures.

6. If a property to be modified is not owned by the Member, the Case Manager shall obtain signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein. Signatures may be completed using a digital signature based on preference of the individual signing the form.

a. Written consent of the homeowner or property manager, as evidenced by the above-mentioned signatures, is required for all projects that involve permanent installation within the Member's residence or installation or modification of any equipment in a common or exterior area.

b. If the Member vacates the property, these signatures can be used as evidence that the homeowner or property manager agrees to allow the Member to leave the modification in

place or remove the modification as the Member chooses. If the Member chooses to remove the modification, the property must be left equivalent or better to its pre-modified condition. The homeowner or property manager may not hold any party responsible for removing all or part of a home modification project.

7. If the Case Management Agency does not comply with the process described above resulting in increased cost for a home modification, the Department may hold the Case Management Agency financially liable for the increased cost.

8. The Department or its agent may conduct on-site visits, or any other investigations deemed necessary prior to approving or denying the Home Modification request.

8.75254.F Home Accessibility Modifications and Adaptations Provider Agency Requirements

1. Home Modification Providers Agencies shall conform to Provider Agency regulations set forth in Section 8.7400.

2. Home Modification Provider Agencies shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county.

3. Home Modification Provider Agencies shall begin work within 60 days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the ~~p~~Provider Agencies~~'s~~ control upon request by the ~~p~~Provider Agency. Requests must be received within the original deadline period and be supported by documentation, including Member notification. Reimbursement may be reduced for delays in accordance with Section 8.75254.F.6.

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

   b. Projects shall be completed within 30 days of beginning work. Extensions of time may be granted by Division of Housing (DOH) or the Department for circumstances outside of the ~~p~~Provider Agencies~~'s~~ control upon request by the ~~p~~Provider Agency. Requests must be received within the original deadline period and be supported by documentation, including Member notification. Reimbursement may be reduced for delays in accordance with Section 8.75254.F.6.

4. The Home Modification Provider Agency shall provide a one-year written warranty on materials and labor from the date of final inspection on all completed work and perform work covered under that warranty at their expense.

5. The Home Modification Provider Agency shall comply with the Long Term Services and Supports Home Modification Benefit Construction Specifications developed by the Division of Housing, which may be found on the Department website, and with local, and state building codes.

6. All Home Modification projects within a Department-established sampling threshold shall be inspected upon completion by Division Of Housing, a state, local or county building inspector or a licensed engineer, architect, Contractor or any other person as designated by the Department. Home Modification projects may be inspected by Division Of Housing upon request by the Member at any time determined to be reasonable by DOH or the Department. Members must provide access for inspections.

a. Division Of Housing shall perform an inspection within 14 days of receipt of notification of project completion or receipt of a Member's reasonable request.

b. Division of Housing shall produce a written inspection report within three days of performing an inspection that notes the Member's specific Complaints. The inspection report shall be sent to the Member, Case Manager, and Provider Agency.

c. Home Modification ~~p~~Provider Agencies must repair or correct any noted deficiencies within 20 days, or the time required by the inspection, whichever is shorter. Extensions of time may be granted by Division of Housing or the Department for circumstances outside of the ~~p~~Provider Agencies'~~s~~ control upon request by the ~~p~~Provider Agency. Requests must be received within the original deadline period and be supported by documentation, including Member notification. Reimbursement may be reduced for delays in accordance with Section 8.75254.F.4.

7. Copies of building permits and inspection reports shall be submitted to Division of Housing. If a permit is not required, the Home Modification Provider Agency shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be justification for recovery of payment by the Department.

8.75254.G Home Accessibility Modifications and Adaptations Reimbursement

1. Payment for Home Modification services shall be the prior authorized amount, or the amount billed, whichever is lower. Reimbursement shall be made in two payments per Home Modification.

2. The Home Modification Provider Agency may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

3. The Home Modification Provider Agency may submit a claim for final payment when the Home Modification project has been completed satisfactorily as shown by the submission of the documentation below to Division of Housing:

   a. Signed lien waivers for all labor and materials, including lien waivers from subcontractors;

   b. Required permits;

   c. Photographs taken before and after the Home Modification has been completed;

   d. One-year written warranty on materials and labor; and

   e. Documentation in the Member's file that the Home Modification has been completed satisfactorily through:

      i. Receipt of inspection report approving work from the building inspector or other inspector as referenced at Section 8.75254.E.6;

      ii. Approval by the Member, Guardian, representative, or other designee;

      iii. Approval by the homeowner or property manager; or

      iv. By conducting an on-site inspection.

4. If Division of Housing notifies a Home Modification Provider Agency that an additional inspection is required, the Home Modification Provider Agency may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

5. The Home Modification Provider Agency shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Modification Provider Bid form or Home Modification Provider Change Order form.

    a. All recommended repairs noted on inspections shall be completed before the Home Modification Provider Agency submits a final claim for reimbursement.

    b. If a Home Modification Provider Agency has not completed work satisfactorily, Division of Housing shall determine the value of the work completed satisfactorily by the Provider Agency during an inspection. The Provider Agency shall only be reimbursed for the value of the work completed satisfactorily.

        i. A Home Modification Provider Agency may request Division of Housing perform one redetermination of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the Provider Agency's expense.

6. Reimbursement may be reduced at a rate of 1% of the total project amount every 7 calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies and inspection deficiencies.

    a. Extensions of time may be granted by Division of Housing or the Department for circumstances outside of the ~~p~~Provider Agencies~~'s~~ control upon request by the ~~p~~Provider Agency. Requests must be received within the original deadline period and be supported by documentation, including Member notification.

    b. The Home Modification reimbursement reduced pursuant to this subsection shall be incorporated into the computation of the Member's remaining money.

7. The Home Modification Provider Agency shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Member. The Home Modification Provider Agency may be reimbursed for the installation of Durable Medical Equipment if such installation is outside of the scope of the Member's Durable Medical Equipment benefit.

8. Work that was completed prior to Department approval is not eligible for reimbursement.

8.752~~6~~5 Home Delivered Meals

8.752~~6~~5.A Home Delivered Meals Eligibility

1. Home Delivered Meals is a covered benefit available to Members enrolled in 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. Development Disability Waiver

8.75265.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.

8.75265.C Home Delivered Meals Inclusions

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

8.75265.D Home Delivered Service Requirements

1. The Member's ~~Person-Centered Support Plan~~service plan must specifically identify:
    a. The Member's need for individualized nutritional counseling and development of a Nutritional Meal Plan, 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 and service plan. All Home Delivered Meal services shall be documented in the ~~Person-Centered Support Plan~~service plan.

3. For Members transitioning into the community, the assessed need is documented in the Member's ~~Person-Centered Support Plan~~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.

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.

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

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

8. Meals may be ethnically or culturally tailored.

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.

10. The ~~p~~Provider Agency shall confirm meal 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.

11. For Members transitioning into the community, the providing Agency's certified RD or RDN 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.

12. For Members transitioning into the community, the RD or RDN will review a Member's progress toward the nutritional goal(s) described in the Member's ~~Person-Centered Support Plan~~service plan no less frequently than once per calendar quarter, and more frequently, as needed.

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

    a. For Members transitioning into the community, the RD or RDN 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, and to make corresponding updates to the Person-Centered Support Plan, as needed.

8.752~~65~~.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~~5~~.F Home Delivered 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 ~~p~~Provider Agencies must conform to all general Certification standards, conditions, and processes established in Section 8.7400.

3. The ~~p~~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. Must maintain a Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN) on staff or under contract.

5. The ~~p~~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;

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.

8.75265.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 service plan ~~or Person-Centered Support Plan~~.

8.75276 Homemaker Services

8.75276.A Homemaker Services Eligibility

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

   a. Brain Injury Waiver when the Member is receiving Personal Care as defined at 8.75376

   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

8.75276.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.

8.75276.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, must be completed within the permanent living space.

   b. Homemaker tasks may include:

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

ii. Meal preparation.

iii. Dishwashing.

iv. Bedmaking.

v. Laundry.

vi. Shopping.

vii. 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.

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.

8.75276.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 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 ~~Person-Centered S~~support ~~P~~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 8.75154.02.

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

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

   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.

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

8.75276.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.

   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:

      i. Tasks included in Section 8.75276.C Homemaker Inclusions.

      ii. Proper food handling and storage techniques.

iii. Basic infection control techniques including Universal Precautions.

iv. Informing staff of policies concerning emergency procedures.

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:

i. Train staff on Agency policies and procedures.

ii. Arrange and document training.

iii. Oversee scheduling and notify Members of schedule changes.

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.

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.

8.7527~~5~~6.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.

b. Payment does not include travel time to or from the Member’s residence.

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.

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.

~~8.7526.G Homemaker Remote Supports Option~~

1. A Remote Supports option is available for Homemaker in the following waivers HCBS Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Supported Living Services (SLS) Waiver:

a. Homemaker Remote Support Option Definitions

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

ii. Monitoring Base means the off-site location from which the Remote Supports Provider monitors the Member.

iii. 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.

iv. Remote Support 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 in consultation with their Case Manager.

v. 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,

vi. 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.

b. Homemaker Remote Supports Option Inclusions

i. Remote Supports that help a Member with general household tasks, including meal preparation and routine household care through remote two-way live communication with a remote support service provider are a covered benefit.

ii. Remote Supports includes prompting, coaching, and virtual supervision with Activities of Daily Living, that are documented in the Member's Person-Centered Support Plan.

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

1) Motion sensing system;

2) Radio frequency identification;

3) Live audio feed;

4) Web-based system; or,

5) Another device that facilitates two-way communication.

iv. Remote Supports includes the following general provisions:

1) Remote Supports shall only be approved when it is the Member's preference and will reduce the assessed need for in-person care.

2) 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.

3) Remote Supports shall be provided in real time by awake staff at a Monitoring Base using the appropriate technology. While Remote Support is being provided, the Remote Support staff shall not have duties other than the provision of Remote Supports.

c. Homemaker Remote Supports Option Restrictions and Non-Benefit Items

i. Remote Supports shall be authorized only for Members who have the physical and mental capacity to utilize the particular system requested for that Member.

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

iii. This service is available to Members to foster developmentally appropriate independence and not to replace informal support.

iv. 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.

v. Devices used for communication cannot be mounted in a bedroom or bathroom and must be able to be moved by the Member to a location of their choice.

vi. The following are not benefits of Remote Supports:

1) The cost of meals, household supplies, cell phones, internet access, landline telephone lines, cellular phone voice, or data plans.

2) Augmentative communication devices and communication boards;

3) Hearing aids and accessories;

4) Phonic ears;

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

6) Computers and computer software unrelated to the provision of Remote Supports;

7) Wheelchair lifts for automobiles or vans;

8) Exercise equipment, such as exercise cycles;

9) Hot tubs, Jacuzzis, or similar items.

d. Remote Supports Provider Agency Requirements

i. The Remote Supports Provider must comply with the Provider Agency Regulations at Section 8.7400 and the provider enrollment agreement.

ii. The Remote Supports Provider shall meet with the Member to identify Remote Supports service needs and submit recommendations in a Remote Support Plan to the Member's Case Manager. The Remote Supports Plan must include:

1) The location where the Member will receive the service,

2) A description of tasks/services the Remote Supports Provider will perform for the Member,

3) The technology devices determined necessary to help the Member meet their identified need

4) 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

5) An up-to-date list of Backup Support Person(s).

iii. Remote Supports Providers shall conform to the following standards for electronic monitoring services:

1) 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.

2) 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.

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

4) 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.

5) 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.

iv. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.

iv. 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.

v. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.

vi. 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.

vii. 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.

viii. 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.

ix. When a Member needs assistance, but the situation is not an emergency, the Remote Supports Provider shall:

1) Address the situation from the Monitoring Base, or,

2) Contact the Member's Backup Support Person if necessary.

x. 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.

xi. 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.

xii. The Remote Supports Provider shall maintain daily service provision documentation that shall include the following:

1) Type of Service,

2) Date of Service,

3) Place of Service,

4) Name of Member receiving service,

5) Medicaid identification number of Member receiving service,

6) Name of Remote Supports Provider,

7) Identify the Backup Support Person and their contact information, if/when utilized.

8) Begin and end time of the Remote Supports service,

9) Begin and end time of the Remote Supports service when a Backup Support Person is needed on site,

10) Begin and end time of the Backup Support Person when on site, whether paid or unpaid,

11) Number of units of Remote Supports service delivered per calendar day,

12) Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the individual's current Service Plan, which shall be communicated to the individual's Case Manager.

e. Homemaker Remote Supports Option Reimbursement

i. 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.

~~ii. There shall be no reimbursement for Remote Supports in Provider -Owned, -Controlled, or Congregate Facility settings.~~

8.7528~~7~~ In-Home Support Services (IHSS)

8.7528~~7~~.A In-Home Support Services Eligibility

1. In-Home Support Services (IHSS) is a covered benefit available to Members enrolled 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~~7~~.B In-Home Support Services Definitions pertaining to Section 8.7528

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 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~~7~~.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 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.

    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~~7~~.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

4. Service Inclusions:

a. Homemaker inclusions are set forth at Section 8.75276.C.

b. Personal Care inclusions are set forth at Section 8.75386.C.

c. Health Maintenance Activities inclusions are set forth at Section 8.75232.C.

8.75287.E In-Home Support Services (IHSS) Exclusions and Limitations

1. In-Home Support Services (IHSS) is a covered benefit for 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 ~~Direct Care Worker~~ in the community is reimbursable. ~~Provider~~ 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 pursuant to In-Home Support Services regulations at Section 8.7538~~6~~.D.1.d.iii.1.c

8.7528~~7~~.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 described 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~~7~~.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 be in compliance 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 CCR 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~~7~~.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 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.

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.

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 8.75287.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.

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.

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.

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~~8~~ years of age and demonstrate competency in caring for the Member to the satisfaction of the Member or Authorized Representative.

i. Minor attendants 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~~7~~.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 as defined in Section 25.5-6-1203, 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~~7~~.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 if requested by the Member as described at Section 8.7200.B.27, 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 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 defined at 8.75287.C, 8.75287.H.5, 8.75287.H.9, and 8.75287.I.3 of this rule have been met.

b. The Case Manager shall follow the Department's utilization management review process and receive authorization prior to authorizing a start date for Attendant services for 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.

8.75287.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 8.75386 Personal Care. IHSS Homemaker services must comply with the rules for reimbursement set forth at Section 8.75276 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 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. Payment does not include travel time to or from the Member's residence.

8.75287.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 8.75287.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.

8.75298 Independent Living Skills Training

8.75298.A Independent Living Skills Training Eligibility

1. Independent Living Skills Training is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.75298.B Independent Living Skills Training Descriptions and Definitions

1. Independent Living Skills Training (ILST) means services designed and developed based on the Member's ability to independently sustain themselves physically, emotionally, and economically in the community. ILST may be provided in the Member's residence or in the community.

2. ILST ~~Person-Centered Support~~Service Plan ~~s are~~means a person-centered plan~~s~~ that describes the ILST services necessary to enable the Member to independently sustain themselves physically, emotionally, and economically in the community. This plan is developed with the Member and the ~~p~~Provider Agency.

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

~~4. The Person-Centered Support Plan is a plan of care created by a process that is driven by the individual and may also include people chosen by the individual, as well as the appropriate health care professional and the designated ILST trainer(s). It provides necessary information and support to the Member to ensure that they direct the process to the maximum extent possible. It documents Member choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the Member needs to function safely in the community. This plan is developed by the Member, provider, and Case Manager.~~

8.75298.C Independent Living Skills Training Inclusions

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

   a. Self-care, including but not limited to basic personal hygiene;

   b. Medication supervision and reminders;

   c. Household management;

   d. Time management skills training;

   e. Safety awareness skill development and training;

   f. Task completion skill development and training;

   g. Communication skill building;

   h. Interpersonal skill development;

   i. Socialization, including but not limited to acquiring and developing appropriate social norms, values, and skills;

   j. Recreation, including leisure and community integration activities;

   k. Sensory motor skill development;

   l. Benefits coordination, including activities related to the coordination of Medicaid services;

   m. Resource coordination, including activities related to coordination of community transportation, community meetings, neighborhood resources, and other available public and private resources;

n. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting.

2. All Independent Living Skills Training shall be documented in the ~~Person-Centered Support Plan~~ILST service plan. Reimbursement is limited to services described in the ~~Person-Centered Support Plan~~ILST service plan.

8.75298.D Independent Living Skills Exclusions and Limitations

1. Benefit is not provided for Members who reside in a Supportive Living Program (SLP) as defined in Section 8.75047.

2. Travel to and from the Member's home is not reimbursable.

8.75298.E Independent Living Skills Training Provider Agency Requirements

1. Provider Agencies must have valid licensure and ~~C~~certification as well as appropriate professional oversight.

a. Agencies seeking to provide ILST services must have a valid Home Care Agency Class A or B license or an Assisted Living Residency license and Transitional Living Program Certification from the Department of Public Health and Environment.

b. Agencies must employ an ILST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, Brain Injury, and a degree within a relevant field.

i. This coordinator must review ILST ~~Person-Centered Support~~Service Plans to ensure Member plans are designed and directed at the development and maintenance of the Member's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

c. Any component of the ILST service plan that may contain activities outside the scope of the ILST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the Member. These professionals must hold licenses with no limitations in one of the following professions:

i. Occupational Therapist;

ii. Physical Therapist;

iii. Registered Nurse;

iv. Speech Language Pathologist;

v. Psychologist;

vi. Neuropsychologist;

vii. Medical Doctor;

viii. Licensed Clinical Social Worker;

ix. Licensed Professional Counselor.

d. Professionals providing components of the ILST service plan may include individuals who are Members of Provider Agency staff, contracted staff, or external licensed and certified professionals who are fully aware of duties conducted by ILST trainers.

e. All ILST ~~Person-Centered Support Plans~~service plans containing any professional activity must be reviewed and authorized at least every 6 months, or as needed, by professionals responsible for oversight as referenced in 8.752~~98~~.E.1.c.i-iii

2. ILST trainers must meet one of the following education, experience, or ~~C~~certification requirements:

a. Licensed health care professionals with experience in providing functionally based ~~A~~assessments and skills training for individuals with disabilities; or

b. Individuals with a bachelor's degree and one (1) year of experience working with individuals with disabilities; or

c. Individuals with an associate degree in a social service or human relations area and two (2) years of experience working with individuals with disabilities; or

d. Individuals currently enrolled in a degree program directly related to but not limited to special education, occupational therapy, therapeutic recreation, and/or teaching with at least three (3) years of experience providing services similar to ILST services; or

e. Individuals with four (4) years direct care experience teaching or working with individuals with a Brain Injury or other cognitive disability either in a home setting, hospital setting, or rehabilitation setting.

3. The Provider Agency shall administer a series of training programs to all ILST trainers.

a. Prior to delivery of and reimbursement for services, ILST trainers must complete the following trainings:

i. Person-centered care approaches;

ii. HIPAA and Member confidentiality;

iii. Basics of Brain Injury including at a minimum:

1) Basic neurophysiology;

2) Impact of a Brain Injury on an individual;

3) Epidemiology of Brain Injury;

4) Common physical, behavioral, and cognitive impairments and interactions strategies;

5) Best practices in Brain Injury recovery; and

6) Screening for a history of Brain Injury.

iv. On-the-job coaching by an incumbent ILST trainer;

v. Basic safety and de-escalation techniques;

vi. Training on community and public resource availability;

vii. Understanding of current brain injury recovery guidelines; and

viii. First aid.

b. ILST trainers must also receive ongoing training, required annually, in the following areas:

i. Cultural awareness;

ii. Updates on Brain Injury recovery guidelines; and

iii. Updates on resource availability.

8.75298.F Independent Living Skills Training Provider Agency Reimbursement

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

8.753029 Life Skills Training

8.75297530.A Life Skills Training Eligibility

1. Life Skills Training is a covered benefit available to Members enrolled in one of the following HCBS waivers:

a. Community Mental Health Supports Waiver

b. Complementary and Integrative Health Waiver

c. Elderly, Blind, and Disabled Waiver

d. Supported Living Services Waiver

8.75297530.B Life Skills Training Descriptions

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

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

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

8.75297530.C Life Skills Training Inclusions

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

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

a. Problem-solving;

b. Identifying and accessing mental and behavioral health services;

c. Self-care and Activities of Daily Living;

d. Medication reminders and supervision, not including medication administration;

e. Household management;

f. Time management;

g. Safety awareness;

h. Task completion;

i. Communication skill building;

j. Interpersonal skill development;

k. Socialization, including, but not limited to: acquiring and developing skills that promote healthy relationships, assistance with understanding social norms and values, and support with acclimating to the community;

l. Recreation, including leisure and community engagement;

m. Assistance with understanding and following plans for occupational or sensory skill development;

n. Accessing resources and benefit coordination, including activities related to coordination of community transportation, community meetings, community resources, housing resources, Medicaid services, and other available public and private resources;

o. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting; and

p. Acquiring and utilizing assistive technology when appropriate and not duplicative of training covered under other services.

8.~~7529~~7530.D Life Skills Training Service Access and Authorization

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

a. The Member demonstrates a need for training designed and directed to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community;

b. The Member identifies skills for which training is needed and demonstrates that without the skills, the Member risks their health, safety, or ability to live in the community;

c. The Member demonstrates that without training they could not develop the skills needed; and

d. The Member demonstrates that with training they have the ability to acquire these skills or services necessary within 365 days.

2. To establish eligibility for Life Skills Training, the Member must satisfy general criteria for accessing the 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 support or resources where they may not otherwise exist.

8.~~7529~~7530.E Life Skills Training Service Requirements

1. The Member's Case Manager must not authorize Life Skills Training for more than 365 days. The Department, in its sole discretion, may grant an exception based on extraordinary circumstances.

2. The LST coordinator must share the LST ~~support~~service plan with the Member' providers of other HCBS services that support or implement any LST services The LST coordinator will seek permission from the Member prior to sharing the LST ~~program Person-Centered Support Plan~~service plan, or any portion of it, with other providers; and

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

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

5. All LST ~~p~~Provider Agencies must maintain a LST ~~support~~service plan that includes:

   a. Monthly skills training plans to be developed and documented;

   b. Skills training plans that include goals, goals achieved or failed, and progress made toward accomplishment of continuing goals;

   c. The start and end time/duration of service provision;

   d. The nature and extent of service;

   e. A description of LST activities;

   f. Progress toward service~~support~~ plan goals and objectives; and

   g. The provider's signature and date.

6. The LST service~~upport~~ plan shall be sent to the Case Management Agency responsible for the Person-Centered ~~s~~Support ~~p~~Plan on a quarterly basis, or as requested by the Case Management Agency.

7. The LST ~~support~~ service plan shall be shared, with the Member's permission, with the Member's ~~p~~other HCBS Provider Agencies ~~of other HCBS services~~.

8.753029.F Life Skills Training Service Exclusions and Limitations

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

2. LST is not to be delivered simultaneously during the direct provision of Adult Day Services, Group Behavioral Counseling, Consumer Directed Attendant Support Services (CDASS), Health Maintenance Activities, Homemaker, In-Home Support Services (IHSS), Mentorship, Peer Mentorship, Personal Care, Prevocational Services, Respite, Specialized Habilitation, Supported Community Connections, or Supported Employment.

    a. LST services may be provided in conjunction with Non-Medical Transportation if it is described in the Member's LST ~~support~~ service plan. Services are billable only when provided by an enrolled NMT ~~p~~Provider Agency, who is not the LST ~~p~~Provider Agency.

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

8.~~7529~~7530.G Life Skills Training Service Provider Agency Requirements

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

2. The Provider Agency must ensure any component of the LST plan that may contain activities outside the scope of the LST trainer's expertise or licensure must be created by an appropriately licensed professional acting within his/her scope of practice.

    a. The professional must hold a license with no limitations in the scope of practice appropriate to meet the Member's LST needs. The following licensed professionals are authorized to furnish LST training:

        i. Occupational Therapist;

        ii. Physical Therapist;

        iii. Registered Nurse;

        iv. Speech Language Pathologist;

        v. Psychologist;

        vi. Neuropsychologist;

        vii. Medical Doctor;

        viii. Licensed Clinical Social Worker

        ix. Licensed Professional Counselor; or

        x. Board Certified Behavior Analyst (BCBA).

    b. An appropriately licensed professional providing a component(s) of the LST service plan may be a Provider~~n~~ Agency staff Member, contract staff Member, or external licensed and certified professionals who are fully aware of duties conducted by LST trainers.

3. A Provider Agency must maintain a Class A or B Home Care Agency License issued by the Colorado Department of Public Health and Environment if that Agency chooses to provide training on Personal Care as defined at Section 8.753~~86~~

4. The Provider Agency must employ one or more LST Trainers to directly support Members, one-on-one, by designing with the Member their LST service~~upport~~ plan and implementing the plan for the Member's training.

   a. An individual is qualified to be an LST trainer only if they are:

      i. A licensed healthcare professional with experience in providing functionally based ~~A~~assessments and skills training for individuals with disabilities;

      ii. An individual with a bachelor's degree and one (1) year of experience working with individuals with disabilities;

      iii. An individual with an associate's degree in a social service or human relations area and two (2) years of experience working with individuals with disabilities;

      iv. An individual currently enrolled in a degree program directly related to special education, occupational therapy, therapeutic recreation, and/or teaching with at least three (3) years of experience providing services similar to LST services;

      v. An individual with four (4) years direct care experience teaching or working with needs of individuals with disabilities; or

      vi. An individual with four (4) years of lived experience transferable to training designed and directed with the Member to develop and maintain his/her ability to sustain himself/herself physically, emotionally, socially and economically in the community. The ~~p~~Provider Agency must ensure that this individual receives Member-specific training sufficient to enable the individual to competently provide LST to the Member consistent with the LST service~~upport~~ plan.

   b. Prior to delivery of and reimbursement for any services, LST trainers must complete the following trainings:

      i. Person-centered support approaches;

      ii. HIPAA and Member's confidentiality;

      iii. Basics of working with the population to be served;

      iv. On-the-job coaching by the provider or an incumbent LST trainer on the provision of LST training;

      v. Basic safety and de-escalation techniques;

      vi. Community and public resource availability; and

      vii. Recognizing emergencies and knowledge of emergency procedures including basic first aid, home and fire safety.

   c. The Provider Agency must ensure that staff acting as LST trainers receive ongoing training within 90 days of unsupervised contact with a Member, and no less than once annually, in the following areas:

i. Cultural awareness;

ii. Updates on working with the population to be served; and

iii. Updates on resource availability.

8.~~75297~~7530.H Life Skills Training Service Provider Agency Reimbursement:

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

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

3. LST may include escorting Members if doing so is incidental to performing an authorized LST service. However, costs for transportation in addition to those for accompaniment may not be billed LST services. If accompaniment and transportation are provided through the same Agency, the person providing transportation may not be the same person who provided accompaniment as a LST benefit to the Member.

8.~~75307~~7531 Massage Therapy

8.~~75307~~7531.A Massage Therapy Eligibility

1. Massage Therapy is a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a. Children with Life Limiting Illness

   b. Children's Extensive Support Waiver

   c. Children's Habilitation Residential Program

   d. Complementary and Integrative Health Waiver

   e. Supported Living Services Waiver

8.~~75307~~7531.B Massage Therapy Definition

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

8.~~75307~~7531.C Massage Therapy Inclusions

1. Massage therapy shall only be used for the treatment of conditions related to the Member's illness, medical need, or behavioral need as identified on the Person-Centered Support Plan.

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

3. Massage Therapy shall be provided in a licensed massage therapist's office, an approved outpatient setting, or in the Member's residence.

4. HCBS Complementary and Integrative Health Waiver (CIH); Support Living Services (SLS)

a. Members receiving massage therapy services may be asked to participate in an independent evaluation to determine the effectiveness of the services.

8.~~75307~~7531.D Massage Therapy Exclusions and Limitations

1. Massage therapy is not available if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.

2. HCBS Support Living Services (SLS) Waiver; Children's Extensive Services (CES) Waiver; Children with Life Limiting Illness (CLLI) Waiver; Children's Habilitation Residential Program (CHRP) Waiver:

   a. The following items are excluded and are not eligible for reimbursement:

      i. Acupuncture;

      ii. Chiropractic care; and

      iii. Experimental treatments or therapies.

3. Massage Therapy Service Limitations:

   a. HCBS Children with Life Limiting Illness Waiver:

      i. Massage Therapy shall be limited to the Member's assessed need up to a maximum of 24 hours per annual certification period.

   b. HCBS Complementary and Integrative Health Waiver:

      i. A maximum of 408 combined units of Acupuncture, Chiropractic, and Massage Therapy Waiver Services may be covered as a benefit during the support plan year.

8.~~75307~~7531.E Massage Therapy Provider Agency Requirements

1. Massage Therapy providers shall be licensed and in good standing pursuant to § 12-235-101, et seq (C.R.S.)

2. HCBS Supported Living Services (SLS) Waiver, HCBS Children's Extensive Services (CES) Waiver; Children's Habilitation Residential Program (CHRP) Waiver:

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

3. HCBS Complementary and Integrative Health Waiver

   a. Massage Therapy providers shall have at least year of experience practicing Massage Therapy at a rate of 520 hours per year; OR year of experience working with individuals with paralysis or other long term physical disabilities.

   b. Massage Therapy Provider Agencies shall:

      i. Determine the appropriate modality, amount, scope, and duration of the massage therapy service within the established limits at Section 8.753~~1~~0.D.3.2.a.

ii. Recommend only services that are necessary and appropriate in a ~~recommendation plan of care~~service plan that the Provider Agency will submit to the Member's Case Manager.

iii. Provide only services in accordance with the Member's prior authorized units.

8.7532 Mental Health Transitional Living Homes

8.7532.A Mental Health Transitional Living Homes Definitions

1. Mental Health Transitional Living Home (MHTL) Certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to the Department after the Provider Agency has met all licensing and regulatory requirements.

2. Protective Oversight is as defined at Section 8.7506.B.2.

8.7532.B Mental Health Transitional Living Homes Member Eligibility

1. Mental Health Transitional Living Homes (MHTL) service is a covered benefit available to Members who meet the following requirements:

   a. Members are determined functionally eligible for Community Mental Health Supports (CMHS) waiver by a Case Management Agency;

   b. Members are enrolled in the HCBS Community Mental Health Supports Waiver; and

   c. Members require the specialized services provided under the Mental Health Transitional Living Homes as determined by assessed need.

8.7532.C Mental Health Transitional Living Homes Inclusions

1. The Mental Health Transitional Living service assists the Member to reside in the most integrated setting appropriate to their needs. Staff will be specifically trained to support Members with a severe and persistent mental illness and who may be experiencing a mental health crisis or episode.

2. This residential service includes the following:

   a. Protective Oversight and supervision;

   b. Assistance with administering medication and medication management;

   c. Assistance with community participation and support in accessing the community;

   d. Assistance with recreational and social activities;

   e. Housing planning and navigation services as appropriate for Members experiencing homelessness/at risk for homelessness;

   f. Life skills training; and

   g. Activities of Daily Living support as needed.

3. Room and board is not a benefit of Mental Health Transitional Living services. Members are responsible for room and board in an amount not to exceed the Department's established rate.

4. Additional services that are available as a State Plan benefit or other HCBS Community Mental Health Supports Waiver service shall not be provided under the Mental Health Transitional Living service.

5. Member engagement opportunities shall be provided by the Mental Health Transitional Living home, as outlined in 6 CCR 1011-1, Chapter VII, Section 12.19-26.

8.7532.D Mental Health Transitional Living Homes Member Rights

1. Members shall be informed of their rights, according to 6 CCR 1011-1, Chapter VII, Section 13 and 10 CCR 2505-10 8.7001. Any modification of those rights shall be in accordance with Section 8.7001.B.4. Pursuant to 6 CCR 1011-1, Chapter VII, Section 13.1, the policy on resident rights shall be in a visible location so that they are always available to Members and visitors.

2. Members shall be informed of all policies specific to the Mental Health Transitional Living setting upon admission to the setting, and when changes to policies are made, rules and/or policies shall apply consistently to the administrator, staff, volunteers, and Members residing in the facility and their family or friends who visit. Member acknowledgement of rules and policies must be documented in the service plan or a resident agreement.

3. If requested by the Member, the Mental Health Transitional Living home shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal possessions.

8.7532.E Mental Health Transitional Living Provider Agency Eligibility

1. To be certified as a Mental Health Transitional Living Provider Agency, the entity seeking certification must be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. VII.

2. Applicants for Mental Health Transitional Living Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by the Colorado Division of Fire Prevention and Control (DFPC).

3. Mental Health Transitional Living Provider Agencies must receive a recommendation for Mental Health Transitional Living Certification. CDPHE issues a recommendation for Mental Health Transitional Living Certification to the Department when the Provider Agency is in full compliance with the requirements set forth in these regulations.

4. No recommendation for Mental Health Transitional Living Certification shall be issued if the owner, applicant, or administrator of the Mental Health Transitional Living home has been convicted of a felony or misdemeanor involving a crime of moral turpitude or that involves conduct that the Department determines could pose a risk to the health, safety, or welfare of the members residing in the Mental Health Transitional Living home.

5. All homes are operated or contracted by the Department of Human Services or Behavioral Health Administration.

8.7532.F Mental Health Transitional Living Provider Agency Roles and Responsibilities

1. Service Requirements

   a. The facility shall provide Protective Oversight and Mental Health Transitional Living services to Members every day of the year, 24 hours per day.

   b. Mental Health Transitional Living Provider Agencies shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 CCR 1011-1, Chapter VII and XXIV, Medication Administration Regulations.

   c. Mental Health Transitional Living Provider Agencies shall not discontinue services to a Member unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services in accordance with 6 CCR 1011-1, Ch. VII Section 11.

   d. The Provider Agency shall encourage and assist Members' participation in engagement opportunities and activities within the Mental Health Transitional Living home community and the wider community, when appropriate.

   e. The Provider Agency shall develop emergency policies that address, at a minimum, a plan that ensures the availability of, or access to, emergency power for essential functions and all member-required medical devices or auxiliary aids.

2. Provider Agency Service Plan

   a. The service plan must outline the goals, choices, preferences, and needs of the Member. Medical information must also be included, specifically:

      i. If the Member is taking any medications and how they are administered, with reference to the Medication Administration Record (MAR);

      ii. Supports needed with Activities of Daily Living;

      iii. Special dietary needs, if any; and

      iv. Reference to any documented physician orders.

   b. Even if recommended by the Member's physician or other practitioner, staff interventions that interfere with the Member's choice of food, freedom to determine their own activities, or exercise of any other rights are Rights Modifications that must comply with Section 8.7001.B.

   ~~b~~c. The service plan must contain evidence that the Member and/or their Guardian or other Legally Authorized Representative has had the opportunity to participate in the development of the plan, as evidenced by the Member or other Legally Authorized Representatives' signature on the plan. The signature may be physical or digital. If the individual is unable to sign the service plan because of a medical condition, any mark the individual is capable of making shall be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a Guardian or other Legally Authorized Representative shall be accepted. ~~the Member and/or their Guardian, designated representative, or Legal Authorized Representative~~

~~has had the opportunity to participate in the development of the service plan, has reviewed it, and has signed in agreement with the plan~~.

3. Environmental Standards

a. The Mental Health Transitional Living Provider Agency shall adhere to regulations at 6 CCR 1011-1, Ch. VII, Sections 15,16, 17, and 19.

4. Staffing

a. The Mental Health Transitional Living home must have appropriate staffing levels to meet the individual acuity, needs and level of assistance required of the Members in the setting.

b. In addition to the trainings outlined in 6 CCR 1011-1, Ch. VII, Section 7, staff must be trained in the following topics prior to working independently with Members:

i. Mental Health First Aid.

ii. Question, Persuade, Refer (QPR).

iii. Suicide and Homicide Risk Screenings.

iv. Trauma Informed Care Methodologies and Techniques.

v. Symptom Management.

vi. Behavior Management.

vii. Motivational Interviewing.

viii. Transitional Planning.

ix. Community Reinforcement and Family Training.

8.7532.G Mental Health Transitional Living Homes Reimbursement

1. Mental Health Transitional Living services are reimbursed on a per diem basis, as determined by the Department. Provider Agencies must be certified and enrolled with the Department prior to rendering services.

2. Additional Charges

a. Provider Agencies shall not bill supplemental charges to any Members, except for amounts designated as copayments by the Department.

i. Federal regulations require that Medicaid Provider Agencies accept Medicaid reimbursements as payment in full (42 C.F.R. § 447.15). Section 25.5-4-301(1), C.R.S., prohibits Provider Agencies from charging Members or their responsible parties for Medicaid services covered under Title XIX of the Social Security Act.

ii. HCBS Members are not liable for the cost or additional cost of any waiver service.

iii. Disallowed supplemental charges include, but are not limited to, any fees such as enrollment fees or one-time fees, annual or monthly fees, registration fees, program placement hold fees, fees for supplies, basic utilities.

3. Provider Agencies may charge room and board, in an amount not to exceed the Department's established rate, per 8.509.50.C.3.

8.753~~1~~3 Mentorship

8.~~753~~17533.A Mentorship Eligibility

1. Mentorship is a covered benefit available to Members enrolled in the HCBS Supported Living Services Waiver.

8.~~753~~17533.B Mentorship Definition

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

8.~~753~~17533.C Mentorship Inclusions

1. Assistance in interviewing potential providers.
2. Assistance in understanding complicated health and safety issues.
3. Assistance with participation on private and public boards, advisory groups and commissions.
4. Training in child and infant care for Members who are parenting children.

8.~~753~~17533.D Mentorship Exclusions and Limitations

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

8.~~753~~17533.E Mentorship Reimbursement

1. Training to a Member that exceeds the 192-unit limit must be authorized by the Department prior to delivery.

8.~~753~~27534 Movement Therapy

8.~~753~~27534.A Movement Therapy Eligibility

1. Movement Therapy is a covered benefit available to Members enrolled in one of the following HCBS waivers:
    a. Children's Extensive Support Waiver
    b. Children's Habilitation Residential Program
    c. Supported Living Services Waiver

8.~~753~~27534.B Movement Therapy Definition

1. Movement Therapy is the use of music therapy and/or dance therapy as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition, and gross motor skills.

8.~~75327~~7534.C Movement Therapy Inclusions

1. Movement Therapy includes the use of music therapy and/or dance therapy when it addresses an assessed need in the Person-Centered Support Plan.

2. Support Living Services (SLS) Waiver:

   a. Movement Therapy includes a pass to community recreation centers and shall only be used to access movement therapy, massage therapy, and hippotherapy services. The pass must be purchased in the most cost-effective manner including day passes or monthly passes.

8.~~75327~~7534.D Movement Therapy Exclusions and Limitations

1. Movement Therapy shall be recommended or prescribed by a therapist or physician who is an enrolled Medicaid ~~p~~Provider. The recommendation must include the medical or behavioral need to be addressed and expected outcome(s) from the therapy. The recommending therapist or physician must monitor the progress and effectiveness of the movement therapy at least quarterly.

2. Movement therapy is only authorized as a treatment strategy for a specific medical or behavioral need and identified in the Member's ~~Person-Centered Support Plan~~service plan.

3. Movement Therapy is not available under the waiver if it is available under the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or from a Third-Party Resource.

4. HCBS Children's Extensive Services (CES) Waiver

   a. The following items are excluded and are not eligible for reimbursement:

      i. Fitness training (personal trainer);

      ii. Warm water therapy;

      iii. Experimental treatments or therapies; and

      iv. Yoga.

5. HCBS Supported Living Services (SLS) Waiver:

   a. The following items are excluded and are not eligible for reimbursement:

      i. Acupuncture;

      ii. Chiropractic care;

      iii. Fitness trainer;

      iv. Equine therapy;

      v. Art therapy;

vi. Warm water therapy;

vii. Experimental treatments or therapies; and

viii. Yoga.

8.~~7532~~7534.E Movement Therapy Provider Agency Requirements

1. Movement therapy shall be provided by a licensed, certified, registered, or accredited professional. Intervention shall be related to an identified medical and/or behavioral need. Movement therapy shall be reimbursed only when:

   a. The provider is licensed, certified, registered or accredited, and In good standing, according to all applicable state licensing requirements for the performance of the Movement Therapy support and services provided. ~~by an appropriate national accreditation association in the profession;~~

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

8.~~7533~~7535 Non-Medical Transportation

8.~~7533~~7535.A Non-Medical Transportation Eligibility

1. Non-medical Transportation (NMT) is a covered benefit available to Members enrolled in 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.~~7533~~7535.B Non-Medical Transportation Definition

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

8.~~7533~~7535.C Non-Medical Transportation Inclusions

1. Non-Medical Transportation is authorized for Organized Health Care Delivery Service (OHCDS), for the reimbursement of purchased bus tickets and passes only, as outlined at Section 8.7202.W.

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

   a. Non-Medical Transportation services shall include, but not be limited to, transportation between the Member's home and non-medical services or supports such as Adult Day Centers, shopping, activities that encourage community integration, counseling sessions

not covered by State Plan, and other services as required by the care plan to prevent institutionalization.

~~2~~3. HCBS Developmental Disabilities (DD) Waiver:

a. Non-Medical Transportation enables Members to gain access to Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services.

~~4~~3. HCBS Supported Living Services (SLS) Waiver:

a. Non-Medical Transportation enables Members to gain access to the community, Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services.

8.~~7533~~7535.D Non-Medical Transportation Exclusions and Limitations

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

a. Non-Medical Transportation services shall not be used to substitute for medical transportation, as defined in Section 8.014.1.

b. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the Person-Centered Support Plan.

c. Non-Medical Transportation services shall only be used after the Case Manager has determined that free transportation is not available to the Member.

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

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

i. A Member is allowed no more than 104 round trip services (208 units), per support plan year, unless otherwise authorized by the Department.

f. HCBS Developmental Disabilities (DD) Waiver:

i. A Member is allowed no more than 254 round trip services (508 units) to and from Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services, per certification period.

g. HCBS Supported Living Services (SLS) Waiver:

i. A Member is allowed no more than 254 round trip services (508) units) to and from Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services, per support plan year.

ii. Transportation in addition to Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services is limited to no

more than 104 round trip services (208 units), per support plan year and will be reimbursed at Mileage Band 1.

8.~~75337~~7535.E HCBS Non-Medical Transportation Provider Agency Requirements

1. Provider Agencies shall maintain all appropriate limits of auto insurance liability as specified in Provider Agency Requirements pursuant to Sections 8.7406(C-D). Provider Agencies shall ensure that each driver rendering NMT meets the following requirements:

   a. Drivers must be 18 years of age or older to render services;

   b. Have at least one year of driving experience;

   c. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history; and

   d. Complete a Colorado or National-based criminal history record check.

2. Drivers shall be disqualified from serving as drivers for any program Members for any of the following:

   a. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;

   b. A conviction in the State of Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;

   c. A conviction in the State of Colorado, within the seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);

   d. A conviction in the State of Colorado, within the four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15 of Title 18, C.R.S.;

   e. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D) within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6114;

   f. A conviction in the State of Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;

   g. A conviction in Colorado within the two (2) years preceding the date the criminal history record check is completed of driving under the influence, as defined in § 42-4-1301(1)(f), C.R.S.; driving with excessive alcohol content, as described in §42-4-1301(1)(g), C.R.S;

   h. A conviction within the two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B), 4 C.C.R. 723-6; § 6114 in any other state or in the United States; and

   i. For purposes of 4 C.C.R. 723-6; § 6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sentence.

3. Vehicles used during the provision of NMT must be safe and in good working order. To ensure the safety and proper functioning of the vehicles, vehicles must pass a vehicle safety inspection prior to it being used to render services.

   a. Safety inspections shall include the inspection of items as described in Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6104.

   b. Vehicles must be inspected on a schedule commensurate with their age:

      i. Vehicles manufactured within the last five (5) years: no inspection.

      ii. Vehicles manufactured within the last six (6) to ten (10) years: inspected every 24 months.

      iii. Vehicles manufactured eleven (11) years or longer: inspected annually.

      iv. Vehicles for wheelchair transportation: inspected annually, regardless of the manufacture date of vehicle.

   c. The vehicle inspector must be trained to conduct the inspection and be employed by an automotive repair company authorized to do business in Colorado.

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

8.~~7533~~7535.F Non-Medical Transportation Provider Agency Reimbursement

1. Reimbursement for ~~n~~Non-~~m~~Medical ~~t~~Transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services.

2. A ~~p~~Provider Agency's submitted charges shall not exceed those normally charged to the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities.

3. Provider Agency charges shall not accrue when the recipient is not physically present in the vehicle.

4. Providers shall not bill for services before they are an approved Medicaid ~~p~~Provider Agency and may bill only for those NMT services performed by a qualified driver utilizing a qualified vehicle.

8.~~7534~~7536 Palliative/Supportive Care

8.~~7534~~7536.A Palliative/Supportive Care Eligibility

1. Palliative/Supportive Care is a covered benefit available to Members enrolled in the HCBS Children with Life Limiting Illness Waiver.

8.~~7534~~7536.B Palliative/Supportive Care Definition

1. Palliative/Supportive Care means a specific program of specialized medical care for Members with life limiting illness offered by a licensed healthcare facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care shall be focused on

providing Members with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal shall be to improve the quality of life for both the Member and the family. Palliative care may be provided to Members of any age and at any stage in a life limiting illness. Palliative care services shall be provided by a Hospice or Home Care Agency staff who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of the CLLI waiver, Palliative Care shall include Care Coordination and Pain and Symptom Management.

8.~~7534~~7536.C Palliative/Supportive Care Inclusions

1. Palliative/Supportive Care may be provided together with curative treatment and includes:

    a. Care Coordination

        i. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the Member and central coordination of medical and psychological services.

        ii. A Care Coordinator will organize an array of services. This approach will enable the Member to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital.

        iii. Additionally, a key function of the Care Coordinator shall be to manage the majority of the responsibility, otherwise placed on the Parents, for condensing, organizing, and making accessible to providers critical information that is related to the care and necessary for effective medical management.

        iv. Care Coordination does not include Case Management Agency or Case Manager responsibilities.

    b. Pain and Symptom Management

        i. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the Member's symptoms and pain. Management includes regular, ongoing pain and symptom Assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms.

        ii. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

8.~~7534~~7536.D Palliative/Supportive Care Provider Agency Requirements

1. Individuals providing Palliative/Supportive Care services shall be employed by or working under a formal contract with a qualified Medicaid hospice or Home Health Agency.

2. The services shall be provided by Hospice or Home Care Agency staff who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss.

8.~~7535~~7537 Peer Mentorship

8.~~7535~~7537.A Peer Mentorship Eligibility

1. Peer Mentorship is a covered service available to Members enrolled in 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.~~75357~~7537.B Peer Mentorship Definition

1. Peer Mentorship means support provided by peers to promote self-advocacy and encourage community living among Members by instructing and advising on issues and topics related to community living, describing real-world experiences as examples, and modeling successful community living and problem-solving.

8.~~75357~~7537.C Peer Mentorship Inclusions

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

2. Peer Mentorship means support provided by peers of the Member on matters of community living, including:

    a. Problem-solving issues drawing from shared experience.

    b. Goal Setting, self-advocacy, community acclimation and integration techniques.

    c. Assisting with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups and commissions.

    d. Activities that promote interaction with friends and companions of choice.

    e. Teaching and modeling of social skills, communication, group interaction, and collaboration.

    f. Developing community-Member relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests.

    g. Assisting the person in acquiring, retaining, and improving self-help, socialization, self-advocacy, and adaptive skills necessary for community living.

    h. Support for integrated and meaningful engagement and awareness of opportunities for community involvement including volunteering, self-advocacy, education options, and other opportunities identified by the individual.

        i. Assisting Members to be aware of and engage in community resources.

8.~~75357~~7537.D Peer Mentorship Service Access and Authorizations

1. To obtain approval for Peer Mentorship, a Member must demonstrate:

    a. A need for soft skills, insight, or guidance from a peer;

    b. That without this service he/she may experience a health, safety, or institutional risk; and

    c. There are no other services or resources available to meet the need.

2. To establish eligibility for Peer Mentorship, 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 support or resources where they may not otherwise exist.

8.~~75357~~7537.E Peer Mentorship Exclusions and Limitations

1. Members may utilize Peer Mentorship up to 24 units (six hours) per day, for no more than 160 units (40 hours) per week, for no more than 365~~-~~ days.

2. Services covered under the State Plan, another waiver service, or by other resources are excluded.

    a. Services or activities that are solely diversional or recreational in nature are excluded.

    b. Peer Mentorship shall not be provided by a peer who receives programming from the same residential location, day program location, or employment location as the Member.

8.~~75357~~7537.F Peer Mentorship Provider Agency Requirements

1. The ~~p~~Provider Agency must ensure services are delivered by a peer mentor staff who:

    a. Has lived experience transferable to support a Member with acclimating to community living through providing them Member advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the Member's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

    b. Is qualified to furnish the services customized to meet the needs of the Member as described in their Person-Centered Support Plan or ~~support~~ service plan;

    c. Has completed training from the Provider Agency consistent with core competencies. Core competencies include:

        i. Understanding boundaries;

        ii. Setting and pursuing goals;

        iii. Advocacy for Independence Mindset;

iv. Understanding of Disabilities, both visible and non-visible, and how they intersect with identity; and

v. Person-centeredness.

8.~~7535~~7537.G Peer Mentorship Documentation

1. All documentation, including but not limited to, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to Section 8.7405 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request, including:

   a. Start and end time/duration of services;

   b. Nature and extent of services;

   c. Mode of contact (face-to-face, telephone, other);

   d. Description of peer mentorship activities such as accompanying Members to complicated medical appointments or to attend board, advisory and commissions meetings, and support provided interviewing potential providers;

   e. Progress toward support and service plan goals and objectives; and

   f. Provider's signature and date.

8.~~7535~~7537.H Peer Mentorship Provider Agency Reimbursement

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

2. Payment for Peer Mentorship shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the ~~support~~ service plan.

8.~~7536~~7538 Personal Care

8.~~7536~~7538.A Personal Care Eligibility

1. Personal Care is a covered benefit available to Members enrolled in 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.~~7536~~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.~~75367~~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 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.

l. Homemaker Services, as described at Section 8.75276, 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:

  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. 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 8.753~~86~~.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.~~7536~~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~~2~~, 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.

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.

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.

d. Family Members shall not be reimbursed for providing only homemaker services. Family Members must provide relative personal care in accordance with the following:

i. Family Members may be employed by certified Personal Care Agencies to provide Personal Care Services to relatives enrolled a waiver subject to the conditions below.

ii. The Family Member shall meet all requirements for employment by a certified personal care Agency and shall be employed and supervised by the personal care Agency.

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:

1) The total number of Medicaid personal care units for a Member of the client's Family shall not exceed the equivalent of 444 hours per support plan year which is equivalent to an average of 1.2164 hours 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.

3) When waiver 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.

iv. Documentation of services provided shall indicate that the provider is a relative when services are provided by a Family Member.

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.

8.~~7536~~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); Supported Living Services (SLS) Waivers:

a. In addition to the training requirements described in Section 8.7400 HCBS Provider Agency Requirements, ~~p~~Personal ~~c~~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. 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. 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 8.75386. 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 previously been involuntarily terminated from Medicaid participation as a personal care/homemaker agency or any other type of service provider.

iv. Abrupt Prior Closure. A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

8.~~7536~~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. The maximum unit rate shall be adjusted by the State as funding becomes available.

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

c. When personal care services are used to provide respite for unpaid primary caregivers, the exact services rendered must be specified in the documentation.

d. If a visit by a personal care staff includes some homemaker services, the entire visit shall be billed as personal care services. If the visit includes only homemaker services, and no personal care is provided, the entire visit shall be billed as homemaker services.

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. There shall be no reimbursement under this section for personal care services provided in certified, uncertified, licensed, or unlicensed Congregate Facilities.

~~8.7536.G Personal Care Remote Supports Option~~

~~1. A Remote Supports option is available for Personal Care in the following waivers: HCBS Elderly, Blind, and Disabled (EBD); Brain Injury (BI); Complementary and Integrative Health (CIH); Community Mental Health Supports (CMHS); Supported Living Services (SLS):~~

~~a. Personal Care Remote Support Option Definitions~~

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

~~ii. Monitoring Base means the off-site location from which the Remote Supports Provider monitors the Member.~~

~~iii. Remote Supports mean 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 other HCBS services.~~

~~iv. Remote Support 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 in consultation with their Case Manager.~~

~~v. 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.~~

~~vi. 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.~~

b. Personal Care Remote Supports Option Inclusions

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

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

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

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

v. The Member's goals and tasks shall be documented in their Person-Centered Support Plan

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

1) Motion sensing system;

2) Radio frequency identification;

3) Live audio feed;

4) Web-based system; or,

5) Another device that facilitates two-way communication.

vii. Remote Supports includes the following general provisions:

1) Remote Supports shall only be approved when it is the Member's preference and will reduce the assessed need for in-person care.

2) 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.

3) Remote Supports shall be provided in real time by awake staff at a Monitoring Base using the appropriate technology. While Remote Support is being provided, the Remote Support staff shall not have duties other than the provision of Remote Supports.

c. Person Care Remote Supports Option Restrictions and Non-Benefit Items

i. Remote Supports shall be authorized only for Members who have the physical and mental capacity to utilize the particular system requested for that Member.

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

iii. This service is available to Members to foster developmentally appropriate independence and not to replace informal support.

iv. Video monitoring by mounted cameras is not allowed. Interactions between the remote support provider and the Member shall be through live two-way communication that is on-demand, scheduled, or alerted by a sensor.

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

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

vii. The following are not benefits of Remote Supports:

1) The cost of cell phones, internet access, landline telephone lines, cellular phone voice, or data plans.

2) Augmentative communication devices and communication boards;

3) Hearing aids and accessories;

4) Phonic ears;

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

6) Computers and computer software unrelated to the provision of Remote Supports;

7) Wheelchair lifts for automobiles or vans;

8) Exercise equipment, such as exercise cycles;

9) Hot tubs, Jacuzzis, or similar items.

d. Personal Care Remote Supports Provider Agency Requirements

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

ii. The Remote Supports Provider will meet with the Member to identify Remote Support service needs and submit the recommendations in a Remote Support Plan to the Member's Case Manager which must include:

1) The location where the Member will receive the service,

2) A description of tasks/services the Remote Supports Provider will perform for the Member,

3) The technology devices determined necessary to help the Member meet their identified need

4) 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

5) An up-to-date list of Backup Support Person(s).

iii. Remote Supports Providers shall conform to the following standards for electronic monitoring services:

1) 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.

2) 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.

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

4) 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.

5) The Remote Support Provider shall provide a Member who receives Remote Supports with initial and ongoing training on how to use the Remote Supports system(s) including regular assurance that the Member knows how to turn on/off systems.

vi. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.

vii. 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.

viii. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.

ix. 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.

x. 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.

xi. 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.

xii. When a Member needs assistance, but the situation is not an emergency, the Remote Supports provider shall:

1) Address the situation from the Monitoring Base, or,

2) Contact the Member's Backup Support Person if necessary.

xiii. 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.

~~xiv. 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.~~

~~xv. The Remote Supports Provider shall maintain daily service provision documentation that shall include the following:~~

~~1) Type of Service,~~

~~2) Date of Service,~~

~~3) Place of Service,~~

~~4) Name of Member receiving service,~~

~~5) Medicaid identification number of Member receiving service,~~

~~6) Name of Remote Supports Provider,~~

~~7) Identify the Backup Support Person and their contact information, if/when utilized.~~

~~8) Begin and end time of the Remote Supports service,~~

~~9) Begin and end time of the Remote Supports service when a Backup Support Person is needed on site,~~

~~10) Begin and end time of the Backup Support Person when on site, whether paid or unpaid,~~

~~11) Number of units of Remote Supports service delivered per calendar day,~~

~~12) Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the individual's current support plan, which shall be communicated to the Member's Case Manager.~~

~~e. Personal Care Remote Supports Option Reimbursement~~

~~i. 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.~~

~~ii. There shall be no reimbursement for Remote Supports in provider-owned, provider-controlled, or congregate settings.~~

8.~~75377~~7539 Prevocational Services

8.~~75377~~7539.A Prevocational Service Eligibility

1. Prevocational services are available as a covered benefit to Members enrolled in one of the following HCBS waivers:
    a. Developmental Disabilities Waiver
    b. Supported Living Services Waiver

8.~~75377~~7539.B Prevocational Service Definition

1. Prevocational services are provided to prepare a Member for paid community employment by increasing general employment skills. Prevocational Services are directed to habilitative rather

than explicit employment objectives and are provided in a variety of locations separate from the Member's private residence or other residential living arrangement.

8.~~7537~~7539.C Prevocational Service Inclusions

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

8.~~7537~~7539.D ~~Service Access & Authorizations~~ Prevocational Service Access and Authorizations

1. Prevocational Services are provided to support the Member to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual Person-Centered Support Plan demonstrates this need based on an annual assessment.

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

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

8.~~7537~~7539.E Prevocational Service Requirements

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

8.~~7537~~7539.F Prevocational Service Exclusions and Limitations

1. Prevocational Services are not primarily directed at teaching job specific skills.

2. One unit is equal to fifteen minutes of service. The following unit limitations apply:

   a. Supported Living Services Waiver:

      i. Prevocational services, in combination with other Day Habilitation services as defined at Section 8.751~~7~~6 and Supported Employment services, are limited to 7,112 units per ~~Person-Centered Support Plan~~support plan year.

   b. Developmental Disabilities Waiver:

      i. Prevocational services, in combination with Day Habilitation services as defined in Section 8.751~~7~~6, are limited to four thousand eight hundred (4,800) units.

      ii. When used in combination with Supported Employment services as defined in Section 8.754~~9~~6, the total number of units available for Prevocational services in combination with Day Habilitation services will remain at 4,800 units, and the cumulative total, including Supported Employment services, may not exceed 7,112 units.

8.7539.F Prevocational Service Provider Agency Requirements

1. Providers of Prevocational Services Program Management shall have either:

   a. Baccalaureate or higher degree from an accredited college or university in the area of Vocational Rehabilitation, Education, Social Work, Psychology or related field and one year of successful experience in human services, or

   b. An associates degree from an accredited college and two years of successful experience in human services, or

   c, Four years successful experience in human services.

8.~~75387~~7540 Primary Caregiver Education

8.~~75387~~7540.A Primary Caregiver Education Eligibility

1. Primary Caregiver Education is a covered benefit available to Members enrolled in the HCBS Children's Extensive Support Waiver.

8.~~75387~~7540.B Primary Caregiver Education Definition

1. Primary Caregiver E~~e~~ducation provides education in techniques that enhance the ability of Parents and other primary caregivers to support a Member's needs and strengths.

8.~~75387~~7540.C Primary Caregiver Education Inclusions

1. Primary Caregiver Education is authorized for Organized Health Care Delivery Service (OHCDS) as outlined at Section 8.7202.W.

2. Primary Caregiver Education includes:

   a. Consultation and direct service costs for training Parents or other primary caregivers in techniques to assist in caring for the Member's needs, including sign language training,

   b. Special resource materials,

   c. Cost of registration for Parents or other primary caregivers to attend conferences or educational workshops that are specific to the Member's disability, and

   d. Cost of membership to caregiver support or information organizations and publications designed for Parents and primary caregivers of children with disabilities.

8.~~75387~~7540.D Primary Caregiver Education Exclusion/Limitations

1. The maximum service limit for P~~p~~rimary ~~c~~Caregiver ~~e~~Education is $1,000 ~~units~~ per support plan year.

2. The following items are specifically excluded and not eligible for reimbursement:

   a. Transportation;

   b. Lodging;

   c. Food; and

   d. Membership to any political organizations or any organization involved in lobby activities.

8.~~75397~~7541 Residential Habilitation Service and Supports

8.~~75397~~7541.A Residential Habilitation Service and Supports Eligibility

1. Residential Habilitation Service and Supports is a covered benefit available to Members enrolled in the HCBS Developmental Disabilities Waiver.

8.~~75397~~7541.B Residential Habilitation Service and Supports Definition

1. Residential Habilitation Service and Supports (RHSS) provide service, supports, and supervision up to 24 hours per day.

8.~~75397~~7541.C Residential Habilitation Service and Supports Inclusions

1. Services are provided to ensure the health, safety and welfare of the Member, and to provide training and habilitation services or a combination of training (i.e., instruction, skill acquisition) and supports in the areas of personal, physical, mental and social development and to promote independence, self-sufficiency and community inclusion. Services and supports are designed to meet the unique needs of each Member determined by the assessed needs, personal goals, and other input provided by the Member Identified Team and to provide access to and participation in typical activities and functions of community life.

2. Members receiving Residential Habilitation Service and Supports must have up to 24-hour supervision. Supervision may be on-site (direct service provider or caregiver is present) or accessible (direct service provider or caregiver is not on site but available to respond when needed). Staffing arrangements must be adequate to meet the health, safety and welfare of the Member and the needs of the Member as determined by the Person-Centered ~~s~~Support ~~p~~Plan. The ~~p~~Provider Agency is responsible for verifying that any direct care provider they employ or contract with has the capacity to serve the Members in their care, as described in the ~~support~~ service plan.

3. Members are presumed able to manage their own funds and possessions unless otherwise documented in the Person-Centered ~~s~~Support ~~p~~Plan and~~or~~ Provider Agency developed service plan.

4. Residential Habilitation Service and Supports includes medical and health care services that are integral to meeting the daily needs of the Member.

    a. Individual Residential Support Services (IRSS)

        i. IRSS includes skilled care that may be performed by a Certified Nursing Assistant (CNA) or lower.

    b. Group Residential Services and Supports (GRSS)

        ii. GRSS includes nursing services set forth at 6 CCR 1011-1 Chapter 8, Part 16.

8.~~75397~~7541.D Residential Habilitation Service and Supports Provider Agency Requirements

1. The ~~p~~Provider Agency must send documented notification to the Member, Guardians, other Legally Authorized Representatives, and the Case Manager at least 30 days prior to proposed changes in setting placements.

    a. If an immediate move is required for the protection of the Member, the ~~p~~Provider Agency must send documented notification to the Member, Guardians, other Legally Authorized

Representatives, and the Case Manager as soon as possible before the move or no later than three days after the move.

b. The Provider Agency must include the Member, Guardians, and other Legally Authorized Representatives, as appropriate, in planning subsequent placements. Any Member of the Member Identified Team may request a meeting to discuss the change in placement.

c. When a Member moves settings or providers, all residential providers involved must be present for the move, or designate an authorized representative to be present, and must ensure all possessions, medications, money and pertinent records are transferred to the Member within 24 hours.

d. A Member, Guardians, or other Legally Authorized Representative, as appropriate, wishes to contest a change in setting shall follow the Grievance procedure of the Agency.

2. The ~~p~~Provider Agency is responsible for monitoring conditions at the setting to ensure compliance and must provide oversight and guidance to safeguard the health, safety, and welfare of the Member.

3. The ~~p~~Provider Agency must provide for and document the regular on-site monitoring of Residential Habilitation Service and Supports. Provider's must conduct an on-site visit of each IRSS or GRSS setting before a Member moves in, and at a minimum once every quarter, with at least one visit annually that is unscheduled. On-site monitoring of IRSS and GRSS settings must include, but not be limited to:

a. Inspection of all smoke alarms and carbon monoxide detectors;

b. Ensuring all exits are free from blockages to egress;

c. Review of each Member's emergency and disaster Assessment; and

d. Medication administration records and physician orders.

8.~~75407~~7542 Individual Residential Service and Supports (IRSS)

8.~~75407~~7542.A Individual Residential Service and Supports (IRSS) Eligibility

1. Individual Residential Service and Supports (IRSS) is a covered benefit available to Members enrolled in the HCBS Developmental Disabilities Waiver.

8.~~75407~~7542.B Individual Residential Service and Supports (IRSS) Definitions

1. Individual Residential Service and Supports (IRSS) use a variety of living arrangements to meet the unique needs for support, guidance and habilitation of each Member.

a. IRSS settings include, but are not limited to:

i. A setting owned, leased or controlled by the Provider Agency;

ii. A setting of a Family member;

iii. The Member's own setting; or

iv. A Host Home.

1) The Host Home is the primary setting of the provider, which means that the Host Home provider occupies the setting 75 percent of the time. The Host Home provider may not contract to provide services to more than three Members, inside or outside of the Host Home, at any given time.

8.~~7540~~7542.C Individual Residential Service and Supports (IRSS) Provider Agency Requirements

1. Oversight

a. The Provider Agency is responsible for controlling the daily operations and management of the Provider Agency and all residential settings in which the Provider Agency employees or contractors provide services. The provider must provide sufficient oversight and guidance and have established written procedures to ensure that the health and medical needs of the Member are addressed. This includes:

i. Each Member must have a primary physician;

ii. Each Member must receive a medical evaluation at least annually unless a greater or lesser frequency is specified by their primary physician. If the physician specifies an annual evaluation is not needed, a medical evaluation must be conducted no less frequently than every two years;

iii. Each Member must be encouraged and assisted in getting a dental evaluation annually;

iv. Other medical and dental assessments and services must be completed as the need for these is identified by the physician, dentist, other medical support personnel or the Member Identified Team; and

v. Records must contain documentation of:

1) medical services provided;

2) results of medical evaluations/assessments and of follow-up services required, if any;

3) acute illness and chronic medical problems; and,

4) weight taken annually or more frequently, as needed.

b. The ~~p~~Provider Agency shall make available to Members nutritionally balanced meals. Based on an Assessment of the Members capabilities, preferences and nutritional needs, the provider may provide guidance and support to monitor nutritional adequacy. The assessment would include not only the nutritional needs of the Member but also their abilities to cook and eat independently.

i. Therapeutic diets must be prescribed by a licensed physician or dietician.

ii. Even if recommended by the Member's physician or other practitioner, staff interventions that interfere with the Member's choice of food, freedom to determine their own activities, or exercise of any other rights are Rights Modifications that must comply with Section 8.7001.B.

c. IRSS may be provided to no more than three Members in a single setting. For each Member in a setting, the ~~p~~Provider Agency must ensure the following criteria are met and documented:

i. The Members involved elect to live in the setting;

ii. Each Member must have their own bedroom, unless they elect to share a bedroom with a roommate of their choice, which must be documented in the ~~Person-Centered sSupport pPlan~~service plan;

iii. Back-up providers are identified, available and agreed upon by the Member and provider. When a back-up provider is not available, the ~~p~~Provider Agency assumes responsibility for identifying a provider;

iv. The P~~p~~rovider Agency and Case Management Agency of each Member in the setting must be involved in the coordination of placement of each Member;

v. Members are afforded regular opportunities for community inclusion of their choice;

vi. Members are afforded individual choice, including preference to live near family;

vii. Distance from other settings (e.g., apartments, houses) of Members is examined so that persons with Developmental Disabilities are not grouped in a conspicuous manner;

d. For the placement of a Member into a three-person setting, the following factors must be examined and documented to determine reasonableness of the placement:

i. Level of Care and needs of each Member in the setting;

ii. Availability to support and provide supervision to Members; and,

iii. Each Member's ability to evacuate.

e. When three Members reside in a single setting, the P~~p~~rovider Agency must conduct monthly monitoring of the setting.

f. Upon enrollment in services, the P~~p~~rovider Agency must assess each Member's ability to care for their safety needs and take appropriate action in case of an emergency. The Assessment must be kept up to date and, at a minimum, address the following emergencies and disasters:

i. Fire;

ii. Severe weather and other natural disasters;

iii. Serious accidents and illness;

iv. Assaults; and,

v. Intruders.

g. There must be a written plan for each Member addressing how the emergencies specified above will be handled. The plans must be based on an ~~A~~assessment, maintained current and shall, at minimum, address:

i. Specific responsibilities/actions to be taken by the Member, approved caregivers or other providers of supports and services in case of an emergency;

1) How the Member will evacuate in case of fire by specifying, at minimum, two exit routes from floors used for sleeping and the level of assistance needed; and

2) Telephone access (by the Member or with assistance) to the nearest poison control center, police, fire and medical services.

h. Safety plans and evacuation procedures must be reviewed and practiced at sufficient frequency and varying times of the day, but no less than once a quarter, to ensure all persons with responsibilities for carrying out the plan are knowledgeable about the plan and capable of performing it. All safety plans must be on site at the setting and be reviewed by the Provider Agency during each on-site monitoring visit.

i. Each ~~p~~Provider Agency must provide quarterly housing and Member updates to the Department or its agent through a specified data collection platform. Failure to provide these quarterly updates may result in payment suspension.

2. Contracts

a. The ~~p~~Provider Agency must have a written contract with each direct service provider that is not directly employed by the ~~P~~provider Agency and is providing IRSS under the ~~P~~provider Agency's authority, regardless of the setting type. This includes but is not limited to Host Home providers and Family caregivers not directly employed by the ~~P~~provider Agency.

i. A current list of the above-mentioned contracted IRSS providers and their accompanying contracts must be on file with the program approved ~~service~~Provider Agency and a copy must be provided to the Department or its agent upon request.

ii. Each contract must be in writing and contain the following information:

1) Name of contracted IRSS provider;

2) Responsibilities of each party to the contract, including, but not limited to, responsibility for the safety and accessibility of the physical environment of the setting;

3) An agreement outlining the living arrangements, monitoring of the home, IRSS provider's duties, and any limitations on the IRSS providers duties;

4) Expectations that Members be provided opportunities for informed choice over a variety of daily choices similar to those exercised by non-Members;

5) Process for correcting non-compliance;

6) Process for termination of the contract;

7) Process for modification or revision of the contract;

8) Process for relocation of the Member if they are in immediate jeopardy of actual or potential for serious injury or harm;

9) Process for coordinating the care of the Member;

10) Payment rate and method;

11) Beginning and ending dates; and

12) A clause that states the contracted IRSS provider shall not sub-contract with any entity to perform in whole the work or services required under the IRSS benefit.

iii. If a contract is terminated with a contracted IRSS provider due to health, safety or welfare concerns, the provider must report to the following parties:

1) Within four days to the Department or its agent regarding the cited reason for termination of a contracted IRSS provider.

2) Within four days to the Guardian or other Legally Authorized Representative and Case Manager of the Member.

iv. The ~~p~~Provider Agency must require each contracted direct service provider providing IRSS to document each approved caregiver(s) and report to the Provider Agency the names of all persons that reside in the setting. Members and/or Guardians have a right to request and receive from the rendering provider a list of all direct service and backup providers that are approved to provide them services. No backup provider may be hired without provider approval. The Provider Agency must ensure criminal background checks are completed for any non-Member over the age of eighteen (18) who lives in the setting.

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

3. Living Environment

a. The ~~p~~Provider Agency has the responsibility for the living environment, regardless of the setting type.

b. Settings of Members must, at minimum, meet standards set forth in the Colorado Division of Housing (DOH) IRSS Inspection Protocol. The following setting types must pass the Division of Housing IRSS Inspection Protocol every two years:

i. All Host Homes; and

ii. All IRSS settings that are owned or leased by a provider.

1) All IRSS settings must be announced to and recorded by Division of Housing within 90 days of activation by a provider and the placement of a Member

2) An inspection by Division of Housing is not required prior to the placement of a Member if the setting has been inspected by the provider and passes all residential safety requirements.

c. The ~~p~~Provider Agency must have a protocol in place for the emergency placement of the Member if a setting is deemed not safe by the Division of Housing (DOH)

d. The setting (exterior and interior) and grounds must:

i. Be maintained in good repair;

ii. Protect the health, comfort and safety of the Member; and

iii. Be free of offensive odors, accumulation of dirt, rubbish and dust.

e. There must be two means of exit from floors with rooms used for sleeping. Exits must remain clear and unobstructed.

f. The ~~p~~Provider Agency must ensure entry to the setting and an emergency exit is accessible to Members, including Members utilizing a wheelchair or other mobility device.

g. Bedrooms must meet minimum space requirements (single 100 square feet, double 80 square feet per person). (Not applicable for studio apartments.)

h. Adequate and comfortable furnishings and supplies must be provided and maintained in good condition.

i. A fire extinguisher must be available in each setting. Presence of an operational fire extinguisher shall be confirmed by the provider during each on-site monitoring visit.

i. Provider Agencies~~'s~~ must follow manufacturer specifications and expiration dates for all fire extinguishers.

j. Smoke alarms and carbon monoxide detectors must be installed in the proper locations in each home to meet Housing and Urban Development (HUD) requirements and/or local ordinances. Smoke and carbon monoxide detectors shall be tested during each on-site monitoring visit by the provider.

8.~~7541~~7543 Group Residential Services and Supports (GRSS)

8.~~7541~~7543.A Group Residential Services and Supports Eligibility

1. Group Residential Services and Supports (GRSS) is a covered benefit available to Members enrolled in the HCBS Developmental Disabilities Waiver.

8.~~7541~~7543.B Group Residential Services and Supports Definitions

1. Group Residential Services and Supports (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) Members receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment (CDPHE) as a residential care facility or residential community setting for Members with Developmental Disabilities.

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

8.~~7541~~7543.C Group Residential Services and Supports Provider Reimbursement Requirements

1. Reimbursement for GRSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to

assure the health and safety of Members or to meet the requirements of the applicable life safety code.

2. ~~-~~Reimbursement does not include room and board.

8.7544 Remote Supports

8.7544.A Remote Supports Eligibility

1. Remote Supports is a covered benefit available to Members enrolled in 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 pertaining to Section 8.7544

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. 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.

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 instrumental activities of daily living tasks that can be completed through virtual two-way live communication with prompts, supervision, or coach 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 ~~s~~Service ~~p~~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 requested for that Member.

2. Remote Supports shall not be authorized under HCBS if the service or device 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 cannot 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 Support Service Plan that will be sent to the Member's Case Manager. The Remote Supports 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).

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. There shall be no reimbursement for Remote Supports in Provider -Owned, -Controlled, or Congregate Facility settings.

8.~~7542~~7545 Adult Respite

8.~~7542~~7545.A Adult Respite Eligibility

1. Adult Respite is a covered benefit available to Members enrolled in 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.~~7542~~7545.B Adult Respite Definition

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

8.~~7542~~7545.C Adult Respite Inclusions

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

   a. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite Member, as ordered by the physician.

   b. An ~~a~~Alternative ~~c~~Care ~~f~~Facility shall provide all the ~~a~~Alternative ~~c~~Care ~~f~~Facility services as listed at Section 8.750~~5~~6, which are required by the individual respite Member.

   c. Respite may be provided in the Member's home, the home of the respite provider, or in the community.

2. HCBS Brain Injury (BI) Waiver

   a. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite Member, as ordered by the physician.

   b. Respite may be provided in the Member's home, home of the respite provider, or in the community.

3. HCBS Supported Living Services (SLS) Waiver

   a. Respite may be provided in the Member's home;

   b. The private residence of a respite care provider; or

   c. In the community.

8.~~7542~~7545.D Adult Respite Exclusions and Limitations

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

   a. An individual Member shall be authorized for no more than (30) days of respite care in each support plan year unless otherwise authorized by the Department.

   b. Alternative care facilities shall not admit individuals for respite care who are not appropriate for alternative care facility placement, as specified at 8.750~~5~~6.

   c. Only those portions of the facility that are Medicaid certified for nursing facility or alternative care facility services may be utilized for respite Members.

2. HCBS Brain Injury (BI) Waiver

a. An individual Member shall be authorized for no more than a cumulative total of 30) days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home and in a nursing facility.

i. A mix of delivery options is allowable if the aggregate amount of services is less than 30 days, or 720 hours, of respite care.

ii. In-home respite is limited to no more than eight hours per day.

iii. Nursing facility respite is billed on a per diem.

iv. Only those portions of the facility that are Medicaid certified for nursing facility services may be utilized for respite Members.

3. HCBS Supported Living Services (SLS) Waiver

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

b. Respite shall be reimbursed according to a unit rate or daily rate, whichever results in lesser reimbursement.

8.~~75427~~7545.E Adult Respite Provider Agency Requirements

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

a. Respite care standards and procedures for nursing facilities are as follows:

i. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. The contract shall constitute automatic Certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

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

iii. For each HCBS-BI/EBD/CIH/CMHS respite Member, the nursing facility must provide an initial nursing Assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the Member. The chart shall identify the Member as a respite Member. If the respite stay is for 14 days or more, the Minimum Data Set (MDS) shall be completed.

iv. An admission to a nursing facility under HCBS-BI/EBD/CIH/CMHS respite does not require a new Level of Care Screen, Pre-Admission Screening and Resident Review (PASRR) review, an AP-5615 form, a physical, a dietitian Assessment, a therapy Assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than 14 days.

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

vi. The nursing facility shall obtain a copy of the Level of Care Screen and the approved Prior Authorization Request (PAR) form from the Case Manager prior to the respite Member's entry into the facility.

b. Respite care standards and procedures for alternative care facilities are as follows:

i. The alternative care facility shall have a valid contract with the Department as a Medicaid certified HCBS-EBD/CMHS ~~a~~Alternative ~~c~~Care F~~f~~acility ~~p~~Provider Agency. Such contract shall constitute Certification for HCBS-BI/EBD/CIH/CMHS respite care.

ii. For each respite care Member, the ~~a~~Alternative ~~c~~Care F~~f~~acility shall follow normal procedures for care planning and documentation of services rendered.

c. Individual respite care providers shall be employees of certified personal care agencies. Family Members providing respite services shall meet the same competency standards as all other providers and be employed by the certified Provider Agency.

2. HCBS Brain Injury (BI) Waiver

a. Respite care standards and procedures for nursing facilities are as follows:

i. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. The contract shall constitute automatic Certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

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

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

iv. An admission to a nursing facility under HCBS-BI/EBD/CIH/CHMS respite does not require a Level of Care Screen, a Pre-Admission Screening and Resident Review (PASRR) review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than 14 days.

v. The nursing facility shall have written policies and procedures available to staff regarding respite care Members. The policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and

any other policies and procedures which may be useful to the staff in handling respite care Members.

vi. The nursing facility shall obtain a copy of the Level of Care Screen and the approved Prior Authorization Request (PAR) form from the Case Manager prior to the respite Member's entry into the facility.

b. Individual respite care providers shall be employees of certified personal care agencies. Family Members providing respite services shall meet the same competency standards as all other providers and be employed by the certified Provider Agency

8.~~7542~~7545.F Adult Respite Provider Reimbursement Requirements

1. For the HCBS Brain Injury (BI); Elderly, Blind, and Disabled (EBD); Complementary and Integrative Health (CIH); and Community Mental Health Supports (CMHS) Waivers:

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

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

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

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

iv. Respite care reimbursement to ~~a~~Alternative ~~c~~Care ~~f~~Facilities shall be as follows:

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

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

b. Individual respite providers shall bill according to a unit rate or daily institutional Nursing Facility rate, whichever is less.

c. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI/EBD/CIH/CMHS services shall not be reimbursed during the respite stay.

d. There shall be no reimbursement provided under this section for respite care in Uncertified Congregate Facilities.

2. HCBS Supported Living Services (SLS) Waiver:

a. Respite shall be provided according to individual, overnight group, or group rates as defined below:

i. Individual: the Member receives respite in a one-on-one situation. There are no other Members in the setting also receiving respite services. ~~Individual respite occurs for 10 hours or less in a 24-hour period.~~

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

iii. Overnight Group: the Member receives respite in a setting which is defined as a facility that offers 24-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.

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

8.~~7543~~7546 Child Respite

8.~~7543~~7546.A Child Respite Eligibility

1. Child Respite is a covered benefit available to Members enrolled in one of the following HCBS waivers:

a. Children with Life Limiting Illness

b. Children's Extensive Support Waiver

c. Children's Habilitation Residential Program

8.~~7543~~7546.B Child Respite Definition

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

2. Unskilled Respite means services provided to an eligible Member by a trained and unlicensed support staff.

3. Skilled Respite means services provided to an eligible Member by a licensed RN/LPN/or CNA. These services must be considered skilled care.

4. Therapeutic Respite means services provided to an eligible Member by a specially trained and certified support provider for ongoing behavioral support needs.

8.~~7543~~7546.C Child Respite Inclusions

1. HCBS Children's Extensive Supports (CES) Waiver

a. Respite may be provided in the Member home or private residence;

b. The private residence of a respite care provider; or

c. In the community.

2. HCBS Children with Life Limiting Illness (CLLI) Waiver

a. Respite care may be provided in the home;

b. In the community; or

c. In an approved respite center location of a Member.

3. HCBS Children's Habilitation Residential Program Waiver (CHRP) Waiver

a. Respite services may be provided in a certified Foster Care Home;

b. Kinship Foster Care Home;

c. Licensed Residential Child Care Facility;

d. Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours);

e. in the Family home; or

f. or in the community.

g. Overnight or out of home Respite must be in a Foster Care Home, Kinship Home, Group Home, or Residential Child Care Facility (RCCF).

8.~~7543~~7546.D Child Respite Exclusions and Limitations

1. HCBS Children's Extensive Supports (CES) Waiver

a. Respite is to be provided in an age-appropriate manner. Respite is not a covered benefit for Member 11 years of age and younger during the time the primary caregiver is at work, pursuing continuing education or engaging in volunteer activities.

b. When the cost of care during the time the caregiver at work is more for a Member 11 years of age or younger, than it is for same age peers, respite may be used to pay the difference in costs. Caregivers shall be responsible for the basic and typical costs of childcare.

2. HCBS Children with Life Limiting Illness (CLLI) Waiver

a. Respite care shall not be provided at the same time as Home Health or Palliative/Supportive Care services.

8.~~7543~~7546.E Child Respite Provider Reimbursement Requirements

1. HCBS Children's Extensive Supports (CES) Waiver

a. Respite shall be provided according to an individual or group rates as defined below: Individual: the Member receives respite in a one-on-one situation. There are no other Members in the setting also receiving respite services. ~~Individual respite occurs for ten (10) hours or less in a twenty-four (24) hour period.~~

~~b. Individual day: the Member receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty-four (24) hour period. A full day is ten (10) hours or greater within a twenty-four (24)- hour period.~~

b. Unskilled Individual day: the Member receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty-four (24) hour period. A full day is ten (10) hours or greater within a twenty- four (24) hour period.

c. Skilled and Therapeutic Individual day: the Member receives respite in a one-on-one situation for cumulatively more than four (4) hours in a twenty-four (24) hour period. A full day is four (4) hours or greater within a twenty- four (24) hour period.

~~c~~d~~b~~. Overnight group: the Member receives respite in a setting which is defined as a facility that offers twenty-four (24) -hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty-four (24) -hour period shall not exceed the respite daily rate.

~~d~~c~~e~~. Group: the Member receives care along with other individuals, who may or may not have a disability. The total cost of the group rate within a twenty-four (24) -hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:

f~~d~~e. The total amount of respite provided in one support plan year may not exceed an amount equal to 30 ~~)~~day units and 1,880 15-minute units. The Department may approve a higher amount based on a need due to the Member's age, disability or unique Family circumstances.

g~~e~~f. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or other services not covered by the HCBS-CES waiver.

h~~g~~f. Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.

i~~g~~h. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a Member. Therefore, additional respite units beyond the service limit will not be approved for Members who receive skilled nursing, certified nurse aide services, or home care allowance from the primary caregiver.

2. HCBS Children with Life Limiting Illness (CLLI) Waiver

   a. Respite is not to exceed thirty (30) days per support plan year, as determined by the Department approved Assessment.

3. HCBS Children's Habilitation Residential Program Waiver (CHRP) Waiver

   a. The total amount of respite provided in one support plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units, where one unit is equal to 15 minutes. The Department may approve a higher amount when needed due to the Member's age, disability or unique Family circumstances.

   b. During the time when Respite care is occurring, the Foster Care Home or Kinship Care Home may not exceed six (6) foster children or a maximum of eight (8) total children, with no more than two (2) children under the age of ~~(~~two~~)~~ (2). The respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.

c. Respite is available for children or youth living in the Family home and may not be utilized while the Member is receiving Habilitation services.

8.~~75447547~~ Specialized Medical Equipment and Supplies

8.~~75447547~~.A Specialized Medical Equipment and Supplies Eligibility

1. Specialized medical equipment and supplies is a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a. Brain Injury Waiver

   b. Children's Extensive Support Waiver

   c. Developmental Disabilities Waiver

   d. Supported Living Services Waiver

8.~~75447547~~.B Specialized Medical Equipment and Supplies Definition

1. Specialized ~~m~~Medical ~~e~~Equipment and ~~s~~Supplies (SMES) means devices, controls, or appliances that help the Member perceive, control, or communicate with their environment to increase their ability to perform Activities of Daily Living or remain safely in their home and community.

8.~~75447547~~.C Specialized Medical Equipment and Supplies Inclusions

1. Specialized Medical Equipment and Supplies is authorized for Organized Health Care Delivery Service (OHCDS) as outlined at Section 8.7202.W.

2. Specialized ~~m~~Medical ~~e~~Equipment and S~~s~~upplies include devices, controls, or appliances that help the Member perceive, control, or communicate with their environment to increase their ability to perform Activities of Daily Living or remain safely in their home and community.

~~2~~3. Devices, controls or appliances that enable the Member to increase their ability to perform Activities of Daily Living,

~~3~~4. Devices, controls or appliances that enable the Member to perceive, control or communicate within their environment,

~~4~~5. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

~~5~~6. Durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to Member's needs assessed in the Person-Centered Support Plan;

~~6~~7. Necessary medical supplies in excess of Medicaid State Plan limitations or not available under the Medicaid State Plan.

~~7~~8. Maintenance and upkeep of specialized medical equipment purchased through the HCBS waiver.

~~8~~9. All items shall meet applicable standards of manufacture, design and installation.

~~9~~10. HCBS Supported Living Services Waiver, Children's Extensive Supports Waiver

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

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

~~c. Specially designed clothing for a Member if the cost is over and above the costs generally incurred for a Member's clothing;~~

8.~~7544~~7547.D Specialized Medical Equipment and Supplies Exclusions and Limitations

1. Specialized ~~m~~Medical ~~e~~Equipment and ~~s~~Supplies exclude~~s~~ those items that are not of direct medical or remedial benefit to the Member as assessed through their Person-Centered Support Plan.

2. Durable and non-durable medical equipment available under the Medicaid State Plan

3. Items that are not of direct medical or remedial benefit to the Member include vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items and wipes for any purpose other than incontinence are not covered under this service.

8.~~7545~~7548 Substance Use Counseling

8.~~7545~~7548.A Substance Use Counseling Eligibility

1. Substance Use Counseling is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.~~7545~~7548.B Substance Use Counseling Definition

1. Substance Use Counseling services shall be designed to support the Member in managing and/or overcoming substance use. These services are in addition to counseling services available through State Plan services and are not intended to replace these services.

8.~~7545~~7548.C Substance Use Counseling Inclusions

1. Outpatient individual, group, and Family counseling services may be provided in the home, community, or provider's office.

2. Substance abuse services are provided in a non-residential setting and must include Assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver Member, Family or caregivers when appropriate, periodic Reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, Family counseling for persons if directly involved in the support system of the Member, interdisciplinary care coordination meetings, and an aftercare plan staffed with the Case Manager.

3. Counseling services are limited to 30 units of individual, group, family, or a combination of counseling services. The Department may authorize additional units based on needs identified in the Person-Centered Support Plan or service~~support~~ plan.

8.~~7545~~7548.D Substance Use Counseling Exclusions and Limitations

1. Inpatient treatment is not a covered benefit.

8.~~7545~~7548.E Substance Use Counseling Provider Agency Requirements

1. Substance abuse services may be provided by any Provider Agency or individual licensed by the Behavioral Health Administration (BHA) and certified by the Department of Health Care Policy and Financing (HCPF).

2. Providers must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to Members with substance abuse problems. The provider shall promote training to improve the ability of the community resources to provide ongoing support to Members living with a Brain Injury.

3. Counselors shall be certified at the Certified Addiction Specialist, Licensed Addictions Counselor level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any Member with a Brain Injury or their Family Members.

8.~~7545~~7548.F Substance Use Counseling Reimbursement

1. There are three separate counseling services allowable under HCBS-BI counseling services including Family Counseling (if the Member is present), Individual Counseling, and Group Counseling each reimbursed on a 1 unit = 1 hour basis

8.~~7546~~7549 Supported Employment

8.~~7546~~7549.A Supported Employment Service Eligibility

1. Supported Employment is a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a. Developmental Disabilities Waiver

   b. Supported Living Services Waiver

8.~~7546~~7549.B Supported Employment Service Definition

1. Supported Employment services are services provided to Members who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive employment, customized employment, or self-employment. The outcome of this service shall be sustained paid employment in a job that meets personal and career goals. The job shall be in an integrated setting in the general workforce and must be compensated at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Covered Supported Employment services include Job Development, Job Placement, Job Coaching, and Workplace Assistance.

8.~~7546~~7549.C Supported Employment Service Inclusions

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

2. Supported ~~e~~Employment may be delivered in a variety of settings in which Members have the opportunity to interact regularly with individuals without disabilities, other than those individuals who are providing services to the Member.

3. Supported ~~e~~Employment shall support Members in achieving sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

4. Group ~~e~~Employment services (e.g. mobile crews) shall be available to a small group two to eight persons~~,~~ and shall be provided in community business and industry settings.

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

6. Supported ~~e~~Employment includes activities needed to sustain paid work by Members including supervision and training.

7. If a Member is employed, the supervision the Member needs while at work shall be clearly documented in their Person-Centered Support Plan. A Member's supervision level at work must be based on the Member's specific work-related support needs.

    a. The level of supervision by paid caregivers may be lower at work than in other community settings without impacting the LOC, and the Member shall not be over-supported or limited in their ability to work based on supervision needs identified for other settings.

8.~~7546~~7549.D Supported Employment Service Access and Authorizations

1. Documentation is maintained in the file of each Member receiving this service that the type of employment related support the Member needs is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.)

2. Supported Employment services, in combination with Day Habilitation and Prevocational services are limited to 7,112 units per support plan year. One unit equals 15 minutes of service.

8.~~7546~~7549.E Supported Employment Service Exclusions and Limitations

1. Supported Employment services do not include payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business.

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

3. Supported ~~e~~Employment shall not take the place of nor shall it duplicate services received through the Division for Vocational Rehabilitation.

4. The following are not a benefit of ~~s~~Supported ~~e~~Employment and shall not be reimbursed:

    a. Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a ~~s~~Supported ~~e~~Employment;

    b. Payments that are distributed to users of ~~s~~Supported ~~e~~Employment; and

c. Payments for training that are not directly related to a Member's ~~s~~Supported ~~e~~Employment.

8.~~7546~~7549.F Supported Employment Service Provider Agency Requirements

1. Supported Employment service providers, including Supported Employment professionals who provide individual Competitive Integrated Employment, as defined in 34 C.F.R. § 361.5(c)(9) (2023), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and Certification requirements.

2. Reimbursement for Supported Employment services training is subject to the availability of appropriations in Section 8.754~~6~~9.G. Provider Agencies must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment Certification (Certification).

3. Deadlines.

   a. Existing staff employed by the Provider Agency on or before July 1, 2019 must obtain a Training Certificate or a Certification no later than July 1, 2024.

   b. Newly hired staff, employed by the Provider Agency after July 1, 2019 must obtain a Training Certificate or a Certification no later than July 1, 2024.

   c. Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

4. Department approval required.

   a. The Training Certificate or Certification required under Section 8.754~~6~~9.F.2 must be pre-approved by the Department. Provider Agencies must submit the following information to the Department for pre-approval review:

      i. Provider name.

      ii. A current Internal Revenue Service Form W-9.

      iii. Whether the Provider is seeking approval for:

         1) Training Certificate, or

         2) Certification, or

         3) Training Certificate and Certification.

      iv. Description of training, if applicable, including:

         1) Number of staff to be trained.

2) Documentation that the training is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

v. Description of Certification, if applicable, including:

1) Number of staff to receive Certification.

2) Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

vi. Dates of training, if applicable, including whether a certificate of completion is received.

vii. Date of Certification exam, if applicable.

b. Department approval of a Training Certificate Curriculum will be based on alignment with the following core competencies:

i. Core values and principles of Supported Employment, including the following:

1) All people are capable of full participation in employment and community life. The preferred outcome for all working age persons with disabilities is employment.

ii. The Person-Centered process, including the following:

1) The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-Centered approach includes working with a team where the individual chooses the people involved on the team and receives necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.

iii. Individualized career assessment and planning, including the following:

1) The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.

iv. Individualized job development, including the following:

1) Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.

v. Individualized job coaching, including the following:

1) Providing necessary workplace supports to Members with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.

vi. Job Development, including the following:

1) Effectively engaging employers for the purpose of community job development for Members with significant disabilities, which meets the needs of both the employer and the Member

c. The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and notify the Provider of its determination within 30 days of receiving the pre-approval request under Section 8.754~~6~~9.F.4.a.

8.~~7546~~7549.G Supported Employment Provider Reimbursement Requirements

1. Reimbursement for a Supported Employment Training Certificate or Certification, or both, which includes both the cost of attending a training or obtaining a Certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse Provider Agencies for such costs.

a. Providers seeking reimbursement for completed training or Certification, or both, approved pursuant to Section 8.754~~9~~6.F.4., must submit the following to the Department:

i. Supported Employment providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or Certifications, except for trainings and Certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or Certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

1) Reimbursement requests must include documentation of successful completion of the training or Certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving a reimbursement request pursuant to Section 8.754~~6~~9.G.1.a.i, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification as required by Section 8.754~~9~~6.F.4.c and either notify the provider of the denial or, if approved, reimburse the provider.

a. Reimbursement is limited to the following amounts and includes reimbursement for wages:

i. Up to $300 per Certification exam.

ii. Up to $1,200 for each training.

8.~~7547~~7550 Supported Living Program

8.~~7547~~7550.A Supported Living Program Eligibility

1. Supported Living Program is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver

8.~~7547~~7550.B Supported Living Program Definitions

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

8.~~7547~~7550.C Supported Living Program Inclusions

1. Supportive Living Program services consist of structured services designed to provide:
    a. Assessment;
    b. Protective Oversight and supervision as defined at Section 8.750~~5~~6.B.2;
    c. Behavioral Management and Education;
    d. Independent Living Skills Training in a group or individualized setting to support:
        i. Interpersonal and social skill development;
        ii. Improved household management skills; and
        iii. Other skills necessary to support maximum independence, such as financial management, household maintenance, recreational activities and outings, and other skills related to fostering independence.
    e. Community Participation;
    f. Transportation between therapeutic activities in the community;
    g. Activities of Daily Living (ADLs);
    h. Personal Care and Homemaker services; and
    i. Health Maintenance Activities.
    j. The Supportive Living Program provider shall ensure that each Member is furnished with their own personal hygiene and care items. These items are to be considered basic in meeting a Member's need for hygiene and remaining healthy. Any additional items may be selected and purchased by the Member at their discretion.
2. ~~Person-Centered Support~~Service Planning

a. Supportive Living Program Provider Agencies must comply with the Person-Centered Support Planning process. Providers must work with Case Management agencies to ensure coordination of a Member's Person-Centered Support Plan and service plan. Additionally, Supportive Living Program providers must provide the following actionable plans for all Brain Injury (BI) waiver Members, updated every six (6) months:

i. Transition Planning; and

ii. Goal Planning.

b. These elements of a ~~Person-Centered Support P~~service plan are intended to ensure the Member actively engages in their care and activities and is able to transition to any other type of setting or service when desired.

8.~~7547~~7550.D Supported Living Program Exclusions and Limitations

1. The following are not included as components of the Supportive Living Program:

a. Room and board shall not be a benefit of Supportive Living Program services, as set forth at Section 8.7413.

b. Additional services which are available as a State Plan benefit or other Brain Injury waiver service. Examples include, but are not limited to physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, long-term home health, and private duty nursing.

8.~~7547~~7550.E Supported Living Program Provider Agency Requirements

1. Staffing

a. The Supportive Living Program ~~p~~Provider Agency shall ensure sufficient staffing levels to meet the needs of Members.

b. The operator, staff, and volunteers who provide direct Member care or protective oversight as defined at 8.7506.B.2 must be trained in precautions and emergency procedures, including first aid, to ensure the safety of the Member. Within one month of the date of hire, the Supportive Living Program ~~p~~Provider Agency shall provide adequate training for staff on each of the following topics:

i. Crisis prevention;

ii. Identifying and dealing with difficult situations;

iii. Cultural competency;

iv. Infection control; and

v. Grievance and Complaint procedures.

c. In addition to the requirements of 6 CCR 1011-1 Ch. 7, the Department requires that the program director shall have an advanced degree in a health or human service-related profession plus two years of experience providing direct services to persons with a Brain Injury. A bachelor's or nursing degree with three years of similar experience, or a combination of education and experience shall be an acceptable substitute.

d. The Supportive Living Program shall ensure that provision of services is not dependent upon the use of Members to perform staff functions. Volunteers may be utilized in the home but shall not be included in the ~~p~~Provider Agency's staffing plan in lieu of employees.

2. Environmental and Maintenance Requirements

a. Supportive Living Program providers shall develop and implement procedures for the following:

i. Handling of soiled linen and clothing;

ii. Storing personal care items;

iii. General cleaning to minimize the spread of pathogenic organisms; and

iv. Keeping the home free from offensive odors and accumulations of dirt and garbage.

8.~~7547~~7550.F Supported Living Program Provider Reimbursement Requirements

1. Room and board shall not be a benefit of Supportive Living Program services.

2. Supportive Living Program services shall be reimbursed according to a tiered per diem rate based on Member acuity, using a methodology determined by the Department.

3. Supportive Living Program services are subject to Post Eligibility Treatment of Income (PETI), as described in 8.7202.BB~~8.486.60~~.

8.~~7548~~7551 Therapeutic Life Limiting Illness Support

8.~~7548~~7551.A Therapeutic Life Limiting Illness Support Eligibility

1. Therapeutic Life Limiting Illness Support is a covered benefit available to Members enrolled in the HCBS Children's with Life Limiting Illness Waiver.

8.~~7548~~7551.B Therapeutic Life Limiting Illness Support Definition

1. Therapeutic Life Limiting Illness Support is intended to help the Member and Family in the disease process. Support is provided to the Member to decrease emotional suffering due to health status and develop coping skills. Support is provided to the Member and/or Family Members in order to guide and help them cope with the Member's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child.

8.~~7548~~7551.C Therapeutic Life Limiting Illness Support Inclusions, Exclusions and Limitations

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

2. Therapeutic Life Limiting Illness Support may be provided in individual or group settings.

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

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

8.~~75487~~7551.D Therapeutic Life Limiting Illness Support Provider Requirements

1. Individuals providing Therapeutic Life Limiting Illness Support shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice Agency.

2. Individuals providing Therapeutic Life Limiting Illness Support shall be one of the following:

   a. Licensed Clinical Social Worker (LCSW)

   b. Licensed Professional Counselor (LPC)

   c. Licensed Social Worker (LSW)

   d. Licensed Independent Social Worker (LISW)

   e. Licensed Psychologist; or

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

8.~~7549~~7552 Transition Setup

8.~~7549~~7552.A Transition Setup Eligibility

1. Transition Setup is a covered benefit available to Members enrolled in 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.~~7549~~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.~~7549~~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 $~~1500~~ 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. 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.~~7549~~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.~~7549~~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.~~7549~~7552.F Transition Setup Provider Agency Requirements

1. The ~~p~~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.

8.75~~49.~~52.G Transition Setup Documentation

1. The ~~p~~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 ~~p~~Provider Agency must furnish to the Member a receipt for any services or durable goods purchased on the Member's behalf.

8.~~7549~~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 $~~1,5~~2000 per eligible Member. The Department may authorize additional funds above the $20~~1,5~~00 limit, up to $2,5~~0~~00, 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 ~~Person-Centered Support Plan~~service 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.~~7550~~7553 Transitional Living Program

8.~~7550~~7553.A Transitional Living Program Eligibility

1. Transitional living Program is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.~~7550~~7553.B Transitional Living Program Definition

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

8.~~7550~~7553.C Transitional Living Program Inclusions

1. All services must be documented in an approved plan of care and be prior authorized by the Department.
2. Program services include but are not limited to Assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household.
3. Extraordinary therapeutic needs mean, for purposes of this program, a Member who requires more than three hours per day of any combination of therapeutic disciplines. This includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

8.~~7550~~7553.D Transitional Living Program Exclusions and Limitations

1. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this Level of Care. If a Member requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for the Transitional Living Program service for a Member must be documented and authorized individually by the Department.
2. Transportation between therapeutic tasks in the community, recreational outings, and Activities of Daily Living is included in the per diem reimbursement rate and shall not be billed as separate charges.
3. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.
4. Room and board shall not be a benefit of Transitional Living Program services, set forth at Section 8.7414.
5. Items of personal need or comfort shall be paid out of money set aside from the Member's income and accounted for in the determination of Financial Eligibility for the Brain Injury program.
6. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the Department.

8.~~7550~~7553.E Transitional Living Program Provider Agency Requirements

1. Policies
    a. The Provider Agency shall confirm that Members must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

b. The Provider Agency shall inform Members and Legally Authorized Representatives of the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

c. The Provider Agency shall confirm that Members need available assistance in a congregate setting for safety and supervision and require support in meeting psychosocial needs.

d. The Provider Agency shall confirm that Members require available paraprofessional nursing assistance on a 24-hour basis due to dependence in Activities of Daily Living, locomotion, or cognition.

e. Understanding that Members of transitional living programs frequently experience behavior which may be a danger to themselves or others, the Provider Agency shall ensure the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The Provider Agency shall have written agreements with other providers in the community who may provide short term Crisis intervention to provide a safe and secure environment for a Member who is experiencing severe behavioral difficulties, or who is actively homicidal or suicidal.

f. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve Members for whom they lack adequate resources to ensure safety of program Members and staff.

g. Upon entry into the program, discharge planning shall begin with the Member and family. Transitional living programs shall work with the Member and Case Manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living program services.

h. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

i. During daytime hours, 7:00 am to 7:00 pm, the ratio of staff to Members shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.

j. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Department.

2. Training

a. At a minimum, the program director shall have an advanced degree in a health or human service-related profession plus three years of experience providing direct services to Members with a Brain Injury. A bachelor's degree with five years of experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.

b. Transitional living programs shall demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the Member. These staff Members shall have successfully completed a training program of at least 40 hours duration.

c. Transitional living Program ~~p~~Provider Agencies must satisfactorily complete an introductory training course on Brain Injury and rules and regulations pertaining to transitional living centers prior to Certification of the Transitional living Program.

d. The provider, staff, and volunteers who provide direct Member care or protective oversight as defined at 8.7506.B.2 must be trained in first aid Universal Precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Transitional living Program's certified prior to the effective date of these rules shall have 60 days to satisfy this training requirement.

e. Training in the use of Universal Precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Transitional living Program's certified prior to the effective date of these rules shall have 60 days to satisfy this training requirement.

f. Staffing of the program must include at least one individual per shift who has Certification as a medication aide prior to assuming responsibilities.

8.~~7550~~7553.F Transitional Living Program Provider Reimbursement Requirements

1. Room and board shall not be a benefit of Transitional living Program services.

2. Transitional living Program services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.

8.~~7551~~7554 Vehicle Modifications

8.~~7551~~7554.A Vehicle Modifications Eligibility

1. Vehicle ~~m~~Modifications 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.~~7551~~7554.B Vehicle Modifications Definition

1. Vehicle ~~m~~Modifications means adaptations or alterations to an automobile that are:

   a. The Member's primary means of transportation.

   b. To accommodate the needs of the Member, as a result of the Member's disability and shall not be approved if the need is a typical age-related need.

   c. Are necessary to enable the Member to integrate more fully into the community and to ensure the health and safety of the Member.

8.~~7551~~7554.C Vehicle Modifications Inclusions

1. Vehicle Modifications is authorized for Organized Health Care Delivery Service (OHCDS) as outlined at Section 8.7202.W.

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

8.~~7551~~7554.D Vehicle Modifications Exclusions and Limitations

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

    a. Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the Member;

    b. Purchase or lease of a vehicle; and

    c. Typical and regularly scheduled upkeep and maintenance of a vehicle.

8.~~7551~~7554.E Vehicle Modifications Case Management Agencies Responsibilities

1. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed 10,000 dollars over the five (5) year life of the HCBS waiver without an exception granted by the Department:

    a. The Case Manager may approve Vehicle Modifications when the total cumulative cost is under $10,000 for the cost of Home Modifications, Vehicle Modifications and Assistive Technology.

    b. For modifications with a cumulative total over $10,000, the Case Manager shall obtain approval by submitting a request to the Department.

        i. The Case Manager shall obtain all supporting documentation according to department prescribed processes and procedures.

        ii. An occupational or physical therapist (OT/PT) shall assess the Member's needs and the therapeutic value of the requested Vehicle Modification. When an OT/PT with experience in Vehicle Modification is not available, a qualified individual may be substituted, with Department approval.

        iii. The Case Manager shall obtain at least two bids for the necessary work. If the Case Manager has made three attempts to obtain a written bid from a ~~p~~Provider Agency and the ~~p~~Provider Agency has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid.

2. Requests for costs that exceed a Member's cumulative allotment of $10,000 over the five-year life of the HCBS waiver may be approved by the Department if it:

    a. Ensures the health and safety of the Member;

    b. Enables the Member to function with greater independence within the community ; or

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

3. Case Management Agency approval for a higher amount shall include a thorough review of the current request as well as past expenditures to ensure cost effectiveness, prudent purchases and no unnecessary duplication.

8.~~7551~~7554.F Vehicle Modifications Provider Agency Reimbursement

1. The total cost of Home ~~a~~Accessibility ~~a~~Adaptations, ~~v~~Vehicle ~~m~~Modifications, and ~~a~~Assistive ~~t~~Technology shall not exceed ~~ten thousand ($~~10,000~~)~~ dollars over the five ~~(5)~~ year life of the HCBS waiver without an exception granted by the Department.

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

8.~~7552~~7555 Vision Services

8.~~7552~~7555.A Vision Services Eligibility

1. Vision services is available to Members enrolled in one of the following HCBS waivers:

   a. Developmental Disabilities Waiver

   b. Supported Living Services Waiver

8.~~7552~~7555.B Vision Services Inclusions

1. Vision Services is authorized for Organized Health Care Delivery Service (OHCDS) as outlined at Section 8.7202.W.

2. HCBS Developmental Disabilities (DD) Waiver; Supported Living Services (SLS) Waiver

   a. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a Member who is at least twenty-one (21) years of age.

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

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

      ii. Prior authorized in accordance with Department procedures.

8.~~7553~~7556 Wellness Education Benefit

8.~~7553~~7556.A Wellness Education Benefit Eligibility

1. Wellness Education Benefit is a covered benefit available to Members enrolled Children's Home and Community Based Services (CHCBS) Waiver ~~members~~.

8.~~7553~~7556.B Wellness Education Benefit Definitions

1. Article means a written document that contains text related to health or wellness topics that a ~~m~~Member receives.

2. Article Topic means a health and wellness topic that relates to helping a ~~m~~Member manage health-related issues, achieve goals on their ~~service pla~~Person-Centered Support Plan, and address topics of community living.

3. Mail means the mechanism by which the benefit is sent to the ~~m~~Member through the United States Postal Service ~~(USPS)~~.

4. Plain language means friendly and clear, with a direct, conversational tone and active voice. The information is organized in logical order for the reader. Paragraphs are one-topic and brief, and

sentences are simple and short. Plain language includes using common, everyday vocabulary consistently across correspondence, with few multi-syllable words and few technical or bureaucratic words.

5. Service rendered means the ~~p~~Provider Agency has sent the Wellness Education Benefit.

6. Provider Agency means the entity contracted with the Department to distribute the Wellness Education Benefit.

7. Verified Address means an address that mail can be sent to and received by a ~~m~~Member.

8. Wellness Education Benefit is individualized educational materials designed to reduce the need for a higher level of care by offering educational materials that provide members and their families with actionable tools that can be used to prevent the progression of a disability, increase community engagement, combat isolation, and improve awareness of Medicaid services. The Wellness Education Benefit helps M~~m~~embers and their unpaid caregivers to obtain, process, and understand information that assists with managing health-related issues, promoting community living, and achieving goals identified in their ~~p~~Person-~~c~~Centered ~~s~~Service~~u~~pport ~~p~~Plan~~s~~. Wellness Education Benefit services include varied topics such as engaging in community activities, nutrition, adaptive exercise, balance training and fall prevention, money management, and developing social networks.

8.~~7553~~7556.C Wellness Education Benefit Inclusions

1. The Wellness Education Benefit shall be delivered to the ~~m~~Member's mailing address in a printed format.

2. Article topics can provide the information needed to: Navigate the Medicaid/medical system to achieve better health outcomes, successfully manage chronic conditions in order to decrease risk of nursing facility placement, effectively communicate health and wellness goals, effectively communicate with medical and social service professionals, provide unpaid caregivers with relevant information regarding best practices around support and care of the ~~m~~Member, achieve community living goals identified in the ~~p~~Person-~~c~~Centered ~~s~~Service~~u~~pport ~~p~~Plan by providing simple, actionable suggestions to help support the health and welfare of waiver ~~m~~Members.

3. Article topics shall be written in plain language.

4. The Wellness Education Benefit is delivered no less than once every month, with a maximum of 12 unique education materials per year.

5. Wellness Education Benefit shall be provided in a format that is accessible to the ~~m~~Member at the request of the ~~m~~Member and their support team including, but not limited to, preferred written language. For ~~m~~Members who cannot read standard print and would benefit from an alternative format, educational materials will be sent to ~~m~~Members in the requested accessible format, which may include larger print or braille.

8.~~7553~~7556.D Wellness Education Benefit Restrictions and Exclusions

1. Additional wellness reading materials, software, or subscriptions are excluded from the Wellness Education Benefit.

2. Article topics that do not address community living, Medicaid navigation, health-related issues, health care needs, mental health-related issues, or Person-Centered Support Plan~~support plan~~ goals shall be excluded from this benefit.

3. The ~~WEB~~ Wellness Education Benefit does not duplicate services found in Early and Periodic Screening, Diagnostic, and Treatment. ~~EPSDT.~~

8.~~7553~~7556.E Wellness Education Benefit Provider Requirements

1. Provider Agencies must be contracted with the Department to distribute the Wellness Education Benefit.

2. Wellness Education Benefit Provider Agency shall be responsible for the following tasks:

    a. Receive and manage member data in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) regulations and ensure client confidentiality and privacy.

    b. Translate materials into select languages, as directed by the Department.

    c. Both the Department and Wellness Benefit Provider Agency shall ensure that professionally certified translators and reviewers complete article translations and that translations are linguistically accurate and consistent with the formatting and technical specifications of the original document. Translations will be reviewed for cultural appropriateness before delivery.

    d. Ensure that materials are P~~p~~erson-~~c~~Centered and are formatted in an accessible format, which may include Braille, large print, or high contrast formats.

    e. Maintain records of articles sent to members to prevent duplication of materials.

    f. Conduct member outreach to gather information on how the service has helped M~~m~~embers thrive in the community and meet their health and wellness goals.

    g. Utilize information on the ~~m~~Member's ~~p~~Person-~~c~~Centered ~~s~~Support ~~p~~Plan and updated health conditions to guide the subject matter of the educational materials.

    h. Identify any undeliverable ~~m~~Member addresses prior to each monthly mailing and manage any returned mail by sending the Department electronic, custom-formatted relevant address information. The Department will coordinate with case managers to update the M~~m~~ember's address and send updated addresses to the Provider Agency.

    i. Verify ~~m~~Member addresses data files through the United States Postal Service ~~(USPS)~~ "National Change of Address" ~~(NCOA)~~ database and identify any addresses that are undeliverable by USPS.

        i. The Department will be informed by the Wellness Education Benefit Provider Agency of the ~~mailers~~ educational materials that are undeliverable or returned to sender. An attempt to deliver the following month's service will take place using the following procedure:

1) The Department will notify the Member's Case Management Agencies of any returned or undeliverable mail.

2) Case Management Agencies shall update addresses in accordance with Department guidance.

8.~~7553~~7556.F Wellness Education Benefit Provider Reimbursement Requirements

1. The Wellness Education Benefit is reimbursed based on the number of units of service provided, with one unit equal to one ~~education a~~Article.

2. The Wellness Education Benefit will be delivered once every month, for twelve (12) units.

   a. The Case Manager may authorize up to 12 additional units per ~~service~~ support plan year for the following:

      i. The Wellness Education Benefit was returned to sender as a non-deliverable, and the address is updated in time for the second round of monthly delivery.

      ii. A ~~m~~Member has requested reasonable accommodation for an alternative format, such as braille.

      iii. A ~~m~~Member requests that their representative receives a copy of the benefit to help them better utilize information provided in the benefit.

3. The annual total units that may be authorized for the Wellness Education Benefit shall not exceed 24 units per plan year.

8.~~7553~~7556.G Wellness Education Benefit Case Management Agency Responsibilities

1. Wellness Education Benefit Introduction and Education:

   a. The ~~c~~Case ~~m~~Manager shall provide ~~m~~Member information on the benefits of the Wellness Education Benefit, the types of articles included, and the frequency of delivery.

   b. Through the person-centered planning process, the ~~c~~Case ~~m~~Manager will determine a format that is accessible to the ~~m~~Member including, but not limited to, preferred written language.

2. Case Management Agencies shall update addresses in accordance with Department guidance.

3. The ~~m~~Member may work with their ~~c~~Case ~~m~~Manager to request different subject matter for the educational materials.

4. The ~~c~~Case ~~m~~Manager may work with the ~~p~~Provider Agency to ensure the educational materials are being targeted to meet any new needs the ~~m~~Member may have.

5. Disenrollment

   a. If a ~~m~~Member wants to opt out of the service, the ~~c~~Case ~~m~~Manager shall inform the ~~m~~Member of the possible implications of disenrollment. If a ~~m~~Member disenrolls, the ~~c~~Case ~~m~~Manager must revise the Prior Authorization Request to end-date the Wellness Education Benefit.

   b. The Wellness Education Benefit is recognized as an HCBS service as it relates to CCR 8.7101.35 and may be utilized to maintain waiver eligibility.

c. If services are decreased without the member's agreement, the ~~c~~Case ~~m~~Manager shall notify the ~~m~~Member of the adverse action and of appeal rights, according to Long-Term Care Waiver Program Notice of Action (LTC-803) regulations at Section 8.7206.18.

8.~~7554~~7557 Wraparound Services

8.~~7554~~7557.A Wraparound Services Eligibility

1. Wraparound Services are available as a covered benefit to Members enrolled in the HCBS Children's Habilitation Residential Program Waiver

8.~~7554~~7557.B Wraparound Services Description and Definition

1. Wraparound services align strategies, interventions, and supports for the Member and family, to prevent the need for out of home placement. This service may be utilized in maintaining stabilization, preventing Crisis situations, and/or de-escalation of a Crisis.
2. Wraparound services include Wraparound Plan and Prevention and Monitoring which are billed separately.
3. A Crisis may be self-identified, Family identified, and/or identified by an outside party.
4. Wraparound Service may be provided individually, or in conjunction with the Child and Youth Mentorship service, defined at 8.7512~~1~~.

8.~~7554~~7557.C CHRP Wraparound Plan

1. The Wraparound Facilitator is responsible for the development of a Wraparound Plan with action steps to implement support strategies, prevent, and/or manage a future Crisis to include, but not limited to:
   a. The unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Member and family.
   b. Environmental modifications.
   c. Support needs in the Family home.
   d. Respite services.
   e. Strategies to prevent Crisis triggers.
   f. Strategies for Predictive and/or Increased Risk Factors.
   g. Learning new adaptive or life skills.
   h. Behavioral or other therapeutic interventions to further stabilize the Member emotionally and behaviorally and to decrease the frequency and duration of any future behavioral Crisis.
   i. Medication management and stabilization.
   j. Physical health.
   k. Identification of training needs and connection to training for Family Members, natural supports, and paid staff.

l. Determination of criteria to achieve stabilization in the Family home.

m. Identification of how the plan will be phased out once the Member has stabilized.

n. Contingency plan for out of home placement.

o. Wraparound Support Team may include Family caregivers, other Family Members, service providers, natural supports, professionals, and Case Managers required to implement the Wraparound Plan.

p. Dissemination of the Wraparound Plan to all individuals involved in plan implementation.

2. Revision of strategies shall be a continuous process by the Wraparound Support Team in collaboration with the Member, until the Member is stable and there is no longer a need for Wraparound Support Services.

3. On-going monitoring after completion of the Wraparound Plan may be provided if there is a need to support the Member and their Family in connecting to any additional resources needed to prevent a future Crisis.

8.~~7554~~7557.D Prevention and Monitoring

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

2. Monitoring of the Wraparound Plan shall occur at a frequency determined by the Member's needs and include at a minimum, visits to the Member's home, review of documentation, and coordination with other Professionals and/or Members of the Wraparound Support Team to determine progress.

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

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

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

8.~~7554~~7557.E Wraparound Services Provider Agency Requirements

1. Individuals providing Wraparound Services shall meet the following criteria:

   a. The Wraparound Plan Facilitator shall:

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

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

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

iii. Have received Certification through a Nationally Accredited Wraparound Program.

1) Training and Certification must encompass all of the following:

a) Trauma informed care.

b) Youth mental health first aid.

c) Crisis support and planning.

d) Positive Behavior Supports, behavior intervention, and de-escalation techniques.

e) Cultural and linguistic competency.

f) Family and youth servicing systems.

g) Family engagement.

h) Child and adolescent development.

i) Accessing community resources and services.

j) Conflict resolution.

k) Intellectual and Developmental Disabilities.

l) Mental health topics and services.

m) Substance abuse topics and services.

n) Psychotropic medications.

o) Motivational interviewing.

p) Prevention, detection and reporting of mistreatment, abuse, neglect, and exploitation.

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

8.~~7555~~7558 Workplace Assistance

8.~~7555~~7558.A Workplace Assistance Service Eligibility

1. Workplace Assistance is available to Members enrolled in one of the following HCBS waivers:

a. Developmental Disabilities Waiver

b. Supported Living Services Waiver

8.~~7555~~7558.B Workplace Assistance Service Definition

1. Workplace Assistance provides work-related supports for Members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver that is above and beyond what could be regularly supported by the workplace supervisor, co-workers, or job coach, in order to maintain an individual job in an integrated work setting for which the

Member is compensated at or above minimum wage. Training/Job Coaching, accommodations, technology, and natural supports are to be used first to maximize the Member's independence and minimize the need for the consistent presence of a paid caregiver, through Workplace Assistance. As such, the degree to which the Member must be supported by a paid caregiver through the Workplace Assistance service, shall be based on the specific safety-related need(s) identified in the Person-Centered planning process for the Member at their worksite.

8.~~7555~~7558.C Workplace Assistance Service Inclusions

1. Workplace Assistance:
    a. Is provided on an individual basis, not within a group and cannot overlap with job coaching;
    b. Occurs at the Member's place of employment, during the Member's work hours, and when needed may also be used:
        i. Immediately before or after the Member's employment hours; or
        ii. during work-related events at other locations.
    c. Includes but is not limited to: promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs, redirecting, reminding to follow work-related protocols/strategies, and ensuring other identified needs are met so the Member can be integrated and successful at work; and
    d. May include activities beyond job-related tasks that support integration at work, such as assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events.
2. Workplace Assistance is appropriate for and available to:
    a. Members who require Intensive Supervision or have a documented need which warrants a Rights Modification requiring extensive supervision, such as, a court order or the Member meeting Public Safety Risk or Extreme Risk-to-Self criteria.
    b. Members whose support team agrees there is justification for a paid caregiver to be present for a portion of the hours worked due to safety concerns; and those needs are beyond what could be addressed through natural supports, technology, or intermittent Job Coaching. The specific safety concerns identified by Members and their support teams may include, but are not limited to:
        i. Regularly demonstrating behaviors that cause direct harm to themselves or others; or
        ii. Intentionally or unintentionally putting themselves in unsafe situations frequently; or
        iii. Often demonstrating poor safety awareness or making poor decisions related to personal safety.

8.~~7555~~7558.D Workplace Assistance Service Access & Authorizations

1. Prior to Workplace Assistance being authorized, including at the Person-Centered Support Plan's annual renewal, the Member and their support team shall determine that alternatives to paid

caregiver supports were fully explored, by considering the factors listed below. Documentation of these considerations shall be reflected in the Member's Case Management record.

a. Job Coaching services have been or will be leveraged to promote the Member's independence and minimize the need for the presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, promoting natural supports, integrating technology, and using systematic instruction techniques.

b. The specific safety concern(s) to be addressed and how the Workplace Assistance staff could support the Member in addressing the safety concerns while facilitating integration and independence at work.

c. The nature of the job and work location, the Member's longevity with the employer, the degree of continuity at the Member's place of employment, and the likelihood of the Member putting themselves/others in harm's way, despite training, technology, and cues from natural supports.

d. The Member's desire to have a paid caregiver present for the identified time periods.

e. The Supported Employment provider's informed opinion regarding the need for paid caregiver support beyond intermittent Job Coaching. This opinion shall be grounded in Employment First concepts as evidenced by:

   i. The provider's completion of a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment Certification (Certification); or

   ii. If the Supported Employment provider does not possess this credentialing, then the Supported Employment provider or the Case Manager may consult with:

      1) By someone who does possess either a Training Certificate or Certification

      2) Or a representative from the Department who oversees the Workplace Assistance benefit.

8.~~7555~~7558.E Workplace Assistance Service Exclusions and Limitations

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

2. A total number of 7,112 units per support plan year shall be available for Workplace Assistance services in combination with other Supported Employment and day habilitation services. One unit equals 15 minutes of service.

8.~~7555~~7558.F Workplace Assistance Service Provider Agency Requirements

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

2. The training for Workplace Assistance staff shall:

   a. Include fundamentals of Employment First principles with emphasis on promoting independence and inclusion; and

   b. Provide insight regarding a paid caregiver's role at a Member's place of employment such that the Workplace Assistance staff's presence does not hinder the Member's interaction with co-workers, customers, and other community Members.

8.~~7556~~7559 Youth Day Service

8.~~7556~~7559.A Youth Day Services Eligibility

1. Youth Day Service is a covered benefit available to Members enrolled in the HCBS Children's Extensive Support Waiver.

8.~~7556~~7559.B Youth Day Services Definition

1. Youth Day Service is the care and supervision of Members ages 12 through 17 while the primary caregiver works, volunteers, or seeks employment.

8.~~7556~~7559.C Youth Day Services Inclusions

1. Youth Day Service may be provided in the residence of the Member, the Y~~y~~outh ~~d~~Day ~~s~~Service ~~p~~Provide~~r~~ Agency, or in the community.

2. Youth Day Service shall be provided according to an individual or group rate as defined below:

   a. Individual: the Member receives ~~y~~Youth ~~d~~Day ~~s~~Services with a staff ratio of 1:1, billed at ~~a~~ 15-minute unit. There are no other youth in the setting also receiving Y~~y~~outh ~~d~~Day ~~s~~Service, ~~r~~Respite or third-party supervision.

   b. Group: the Member receives supervision in a group setting with other individuals who may or may not have a disability. Reimbursement is limited to the Member.

8.~~7556~~7559.D Youth Day Services Exclusions and Limitations

1. This service is limited to Members ages twelve (12) through seventeen (17).

2. This service may not substitute for or supplant special education and related services included in a Member's Individualized Education Plan (IEP) developed under Part B of the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 (2011). This includes after school care provided through any education system and funded through any education system for any student.

3. This service may not be used to cover any portion of the cost of camp.

4. This service is limited to ten (10) hours per calendar day and 90 days per certification period~~.~~ The Department may approve a higher amount based on a need due to the Member's disability or unique family circumstances.

8.~~7557~~7560 State Funded Supported Living Services (State-SLS) Program

1. The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide

services to individuals with an intellectual or Developmental Disability to remain in their community. The State-SLS program shall not supplant Home and Community-Based Services for those who are currently eligible.

8.~~7557~~7560.A State-SLS Definitions

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

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

3. Natural Supports means an informal relationship that provides assistance and occurs in the Member's everyday life including, but not limited to, community supports and relationships with Family Members, friends, co-workers, neighbors and acquaintances

4. Performance and Quality Review means a review conducted by the Department or its Contractor at any time to include a review of required Case Management services performed by the Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements

5. State Fiscal Year means a 12-month period beginning on July 1 of each year and ending June 30 of the following calendar year.

8.~~7557~~7560.B State-SLS Administration

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

    a. The Case Management Agency is responsible for providing Case Management to all individuals enrolled in the State-SLS program.

    b. The Case Management Agency shall have written procedures related to the administration, Case Management, service provision, and waiting list for the State-SLS program.

    c. All records must be maintained in accordance with Section 8.7405.

    d. The Case Management Agency shall maintain a waiting list of eligible individuals for whom Department funding is unavailable in accordance with Section 8.756057.G.

    e. The Case Management Agency shall develop procedures for determining how and which individuals on the waiting list will be enrolled into the State-SLS program that comply with all applicable statutory, regulatory and contractual requirements including Section 8.756057.G.

    f. Any decision to modify, reduce or deny services or supports set forth in the State-SLS program, without the Individual's or Legally Authorized Representative's agreement, are subject to the requirements in Section 8.7202.S.

2. Member Eligibility

    a. General Eligibility requirements

        i. Individuals must be a resident of Colorado;

        ii. Be eighteen (18) years of age or older; and

        iii. Be determined to have an intellectual or Developmental Disability pursuant to the procedures set forth in Section 8.7202.D.

    b. Eligibility for the State-SLS program does not guarantee the availability of services under this program.

3. General Provisions

    a. The availability of services offered through the State-SLS program may not be consistent throughout the State of Colorado or between Case Management Agencies.

    b. An individual enrolled in the State-SLS program shall access all benefits available under the Medicaid State Plan, HCBS Waiver or EPSDT, if available, prior to accessing services under the State-SLS program. Services through the State-SLS program may not duplicate services provided through the State Plan when available to the Member.

    c. Evidence of attempts to utilize all other public benefits and available and accessible community resources must be documented in the State-SLS individualized Support Plan by the Case Manager, prior to accessing State-SLS services or funds.

    d. The State-SLS program shall be subject to annual appropriations by the Colorado General Assembly.

    e. These regulations shall not be construed to prohibit or limit services and supports available to persons with Intellectual and Developmental Disabilities that are authorized by other state or federal laws.

    f. When an individual is enrolled only in the State-SLS program the Case Manager shall authorize a Provider Agency to deliver the services, when available.

    g. The Case Manager may authorize services from multiple State-SLS service categories at once, unless otherwise stated.

    h. Unless otherwise specified, State-SLS services may be utilized in combination with other community resources and/or Medicaid services. State-SLS services shall not be duplicative of other resources or HCBS services, and all other available and accessible resources shall be utilized before State-SLS services.

4. Performance and Quality Review

    a. The Department shall conduct a Performance and Quality Review of the State-SLS program to ensure that the Case Management Agency is in compliance with all statutory and regulatory requirements.

    b. A Case Management Agency found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within 10 business days of the date of

the written request from the Department. A Corrective Action Plan shall include, but is not limited to:

i. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;

ii. A detailed timeframe for completing the actions to be taken;

iii. The employee(s) responsible for implementing the actions; and

iv. The estimated date of completion.

c. The Case Management Agency shall notify the Department in writing, within 3 business days if it will not be able to present the Corrective Action Plan by the due date. The Case Management Agency shall explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.

i. Upon receipt of the proposed Corrective Action Plan, the Department will notify the Case Management Agency in writing whether the Corrective Action Plan has been accepted, modified, or rejected.

ii. In the event that the Corrective Action Plan is rejected, the Case Management Agency shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

iii. The Case Management Agency shall begin implementing the Corrective Action Plan upon acceptance by the Department.

iv. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.~~7557~~7560.C State-SLS Inclusions and Covered Services

1. Services for individuals waiting for HCBS waiver enrollment.

a. Eligible Members may receive the following services:

i. All HCBS Waiver Services identified as available to Members enrolled in the SLS waiver as identified throughout section 8.7500 et seq.

ii. Service limitations in the HCBS SLS waiver and set forth in section 8.7500 et seq. apply to the State-SLS program.

iii. When a Provider Agency is not available to provide services, the Case Management Agency may authorize the services identified in the State-SLS Individual Support Plan.

2. Services for Individuals Experiencing Emergency Situations or Temporary Hardships

a. State-SLS may be utilized to provide the following emergency or temporary services to individuals who have been determined to meet the criteria for an Intellectual / Developmental Disability as specified in Section 8.7202.D, in situations where temporary

assistance can alleviate the need for a higher Level of Care. These services cannot be duplicative and shall not be accessed if available through other sources. In order to access State-SLS, an Individual Support Plan must be completed.

i. Payment of utilities:

1) Paying gas/electric bills and/or water/sewer bills:

a) Documentation must be maintained by the Case Management Agency that all alternative programs, community support, and natural supports were utilized before any State-SLS funds were authorized.

ii. Services with acquiring emergency food, at a retail grocery store when there are no other community resources available

1) Documentation must be maintained by the Case Management Agency demonstrating the reason why State-SLS funds were utilized over other sources of emergency food. This may include but is not limited to:

a) Other emergency food programs are not available.

b) Home delivered meals have unexpectedly stopped.

iii. Pest infestation abatement:

1) Documentation must be maintained by the Case Manager showing that infestation abatement is not covered under the Member's residential agreement or lease.

2) Documentation that the pest abatement professional is licensed in the state of Colorado, must be maintained by the Case Management Agency and provided to the Department upon request.

3) Pest infestation abatement shall not be authorized if the Member resides in a provider owned and/or controlled property.

4) Documentation showing proof of payment must be maintained by the Case Management Agency administering the State-SLS program.

b. Service Limitations

i. Support for utilities shall not exceed $1,000.00 in a State Fiscal Year.

ii. Support for pest infestation abatement shall not exceed $2,000.00 in a State Fiscal Year.

1) Supports for pest infestation abatement shall not cover more than one infestation event in a State Fiscal Year; and

2) Multiple treatments per event may be authorized, if determined necessary by a licensed pest abatement professional.

iii. Emergency food support shall not exceed $400.00 in a State Fiscal Year.

3. Services to Support Independence in the Community.

a. State-SLS may be utilized to provide an individual found eligible for or enrolled in an HCBS Medicaid waiver, with a one-time payment or acquisition of needed household items, in the event the Member is moving into a residence as defined in Section 8.7101.I.2.e..

i. State-SLS funds may be utilized for payment or acquisition of:

1) Initial housing costs including but not limited to a one-time initial set up for pantry items and/or kitchen supplies and/or furniture purchase.

ii. Individuals enrolled in the HCBS-DD waiver residing in a Group Residential Services and Supports (GRSS) or Individual Residential Services and Supports - Host Home (IRSS-HH) setting are not eligible for this Support.

b. State-SLS funds may support someone to have greater independence when they are moving into their own home, by paying for housing application fees.

c. The Case Management Agency shall maintain receipts or paid invoices for purchases authorized in this section. Receipts or paid invoices must contain at a minimum, the following information: business name, item(s) purchased, item(s) cost, date paid, and description of items purchased. Documentation must be made available to the Department upon request. All items must be purchased from an established retailer that has a valid business license.

d. Service limitations

i. The one-time furniture purchase shall not exceed $300.00.

ii. The one-time initial pantry set up shall not exceed $100.00.

iii. The one-time purchase of kitchen supplies shall not exceed $200.00.

iv. The payment of housing application fees are limited to five (5) in a State Fiscal Year.

4. On-going State-SLS Support.

a. State-SLS funds may be authorized by the Case Management Agency for individuals who have been determined to meet the DD Determination requirements, but do not meet the requirements to be enrolled in HCBS-SLS Waiver Section 8.7101.I.~~.~~

i. All HCBS Waiver Services identified as available to Members enrolled in the SLS waiver as identified throughout ~~s~~Section 8.7500 et seq.

ii. Service limitations and service rules found in the HCBS-SLS eligible Waiver Services in Section 8.7500 et seq. apply to the State-SLS program.

iii. A Provider Agency is authorized to provide State-SLS services; and

b. When an individual is enrolled in an HCBS waiver, State-SLS services may be utilized in combination with other community resources and/or Medicaid services. State-SLS services shall not be duplicative of other resources or HCBS services, and all other available and accessible resources shall be utilized before State-SLS services.

i. Individuals enrolled in HCBS SLS and HCBS DD shall not use State SLS for ongoing services but may use State SLS for emergency services or temporary hardships only.

ii. Only a Provider Agency can provide these services.

c. Service Limitation

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

8.~~7557~~7560.D State-SLS Individual Support Plan

1. State-SLS Members are required to have a State SLS Individual Support Plan that is signed and authorized by the CMA Case Manager and the Member, or their Legally Authorized Representative.

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

3. If a Member seeks additional services or identifies a change in need, the State-SLS Individual Support Plan shall be reviewed and updated by the Case Manager prior to any change in authorized services.

4. The State-SLS Individual Support Plan shall be effective for no more than one year and reviewed at least every 6 months, in a face-to-face meeting with the Member or on a more frequent basis if a change in need occurs. Upon Department approval, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or Member (e.g. natural disaster, pandemic, etc.)

   a. Any changes to the provision of the services identified in the State-SLS Individual Support Plan are subject to available funds within the defined service area.

   b. Any decision to modify, reduce or deny services set forth in the State-SLS Individual Support Plan, without the Member's consent is subject to the Dispute Resolution Process found in Section 8.7202.S.

5. The State-SLS Individual Support Plan and all supporting documentation will be maintained by the Case Manager and will be made available to the Department upon request.

6. The State-SLS Individual Support Plan shall include the following:

   a. The services authorized, the Member's identified needs and how the services will address the needs.

   b. The scope, frequency, duration, and cost of each service.

   c. Other community resources being utilized.

d. Documentation demonstrating why the individual enrolled in State-SLS is not eligible or enrolled in a HCBS Medicaid waiver or documentation showing which HCBS waiver the individual is enrolled in;

e. Documentation demonstrating if other public or community resources have been utilized and why State-SLS funds are being utilized instead of or in combination with other resources.

f. Total cost of the services being authorized.

g. Information to support authorization of services for Individuals Experiencing Temporary Hardships, including:

i. A description of the hardship.

ii. The reason for the hardship.

iii. The length of time the support will be authorized, including the date of the onset of the hardship and the date it is expected to end.

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

v. A plan to reasonably ensure the hardship is temporary.

vi. A plan to reasonably ensure that dependence on State-SLS funds will be temporary.

vii. The dates of when the long-term solution will be in place and when the temporary hardship is expected to end.

viii. Documentation demonstrating how utilizing State-SLS funds will lead to the Member gaining more independence in the community or maintaining their independence in the community

8.~~7557~~7560.E State-SLS Case Management Services

1. Administration

a. The Case Management Agency shall comply with all requirements set forth in Section 8.7200 et seq.

2. Case Management Duties:

a. The Case Manager shall coordinate, authorize, and monitor services based on the approved State-SLS Individual Support Plan.

i. The Case Manager shall have, based on the Member's preference, a face to face or telephone contact once per quarter with the Member.

b. The Case Manager shall assist Members to gain access to other resources for which they are eligible and to ensure Members secure long-term support as efficiently as possible.

c. The Case Manager shall provide all State-SLS documentation upon the request from the Department.

d. Referrals to the State-SLS program shall be made through the Case Management Agency in the geographic defined service area the Member or Applicant resides in.

8.~~7557~~7560.F State-SLS Transferring Services Between Case Management Agencies

1. When an individual enrolled in, or on the waiting list for, the State-SLS program moves to another Case Management Agency's defined service area, and wishes to transfer their State-SLS, the following procedure shall be followed:

   a. The originating Case Management Agency will contact the receiving Case Management Agency to inform them of the individual's desire to transfer.

   b. The originating Case Management Agency will send the State-SLS Individual Support Plan to the receiving Case Management Agency, where the receiving Case Management Agency will determine if appropriate State-SLS funding is available or if the individual will need to be placed on a waiting list. The receiving Case Management Agency's decision of service availability will be communicated in the following way:

      i. The receiving Case Management Agency will notify the individual seeking transfer of its decision by the individual's preferred method, no later than ten (10) business days from the date of the request; and

      ii. The receiving Case Management Agency will notify the originating Case Management Agency of its decision by U.S. Mail, phone call or email of its decision no later than ten (10) business days from the date of the request.

   c. The decision shall clearly state the outcome of the decision including:

      i. The basis of the decision; and

      ii. The contact information of the assigned Case Manager or waiting list manager.

   d. The originating Case Management Agency shall contact the individual requesting the transfer no more than five (5) days from the date the decision was received to:

      i. Ensure the individual understands the decision; and

      ii. Support the individual in making a final decision about the transfer.

   e. If the transfer is approved, there shall be a transfer meeting in-person when possible, or by phone if geographic location or time does not permit, within fifteen (15) business days of when the notification of service determination is sent out by the receiving Case Management Agency. The transfer meeting must include but is not limited to the transferring individual and the receiving Case Manager. Any additional attendees must be approved by the transferring individual.

   f. The receiving Case Management Agency must ensure that:

      i. the transferring individual meets his or her primary contact of the receiving Case Management Agency.

      ii. The individual is informed of the date when services will be transferred, when services will be available, and the length of time the services will be available.

g. The receiving Case Manager shall have an in-person face to face meeting with the Member to review and update the State-SLS Individual Support Plan, prior to the services being authorized. Upon Department approval, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or Member (e.g. natural disaster, pandemic, etc.).

8.~~7557~~7560.G State-SLS Waiting List Protocol

1. Persons determined eligible to receive services under the State SLS program, shall be eligible for placement on a waiting list for services when state funding is unavailable.

2. Waiting lists for persons eligible for the State SLS program shall be administered by the Case Management Agency, uniformly administered throughout the State and in accordance with these rules and the Department's procedures.

3. Persons determined eligible shall be placed on the waiting list for services in the Case Management Agency service area of residency.

   a. The date used to establish a person's placement on a waiting list shall be:

      i. The date on which an individual is determined eligible for the State-SLS program through the DD Determination and the identification of need.

4. As funding becomes available in the State SLS program in a defined service area, persons shall be considered for services in order of placement on the local Case Management Agency's waiting list.

5. Individuals with no other State or Medicaid funded services or supports will be given priority for enrollment including individuals who lose Medicaid eligibility and lose Medicaid Waiver Services.

6. Exceptions to these requirements shall be limited to:

   a. Emergency situations or temporary hardships where the health, safety, and welfare of the person or others is greatly endangered, and the emergency cannot be resolved in another way. Emergencies are defined as follows:

      i. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; whose primary residence during the night is a public or private facility that provides temporary living accommodations; any other unstable or non-permanent situation; is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

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

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

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

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

7. Documentation demonstrating how the individual meets the emergency criteria shall be kept on file at the Case Management Agency and made available to the Department upon request.

8.~~7557~~7560.H State-SLS Case Management Agency and Provider Agency Reimbursement

1. A Provider Agency must submit all claims, payment requests, and/or invoices to the Case Management Agency for payment within thirty (30) days of the date of service, except for Services and Supports rendered in June, the last month of the State Fiscal Year. All claims, payment requests, and/or invoices for services rendered in June must be submitted by the date specified by the Case Management Agency to ensure payment.

2. Case Management Agency must submit all claims, payment requests, and/or invoices in the format and timeframe established by the Department.

3. Case Management Agency and Provider Agency claims, payment requests, or invoices for reimbursement shall be made only when the following conditions are met:

   a. Services are provided by a qualified Provider Agency.

   b. Services are authorized and delivered in accordance with the frequency, amount, scope and duration of the service as identified in the Member's State-SLS Individual Support Plan;

   c. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the State-SLS Individual Support Plan and in accordance with the service definition;

   d. All Case Management Activities must be documented and maintained by the Case Management Agency.

4. Case Management Agency and Provider Agencies shall maintain records in accordance with Sections 8.130.2 and 8.7405.

5. Case Management Agency and Provider Agency reimbursement shall be subject to review by the Department and may be completed after the payment has been made to the Case Management Agency and Provider Agency.

6. Case Management Agencies and Provider Agencies are subject to all program integrity requirements in accordance with Section 8.076.

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

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

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

8.756158 Family Support Services Program (FSSP)

8.75587561.A FSSP Administration

1. The Case Management Agency (CMA) shall administer the Family Support Services Program (FSSP), subject to available appropriations and according to the rules, regulations, policies and guidelines of the Department, local Family Support Council (FSC) and Case Management Agency.

2. The Case Management Agency shall ensure that the FSSP is implemented within its defined service area.

3. The Case Management Agency shall designate one (1) person as the contact for the overall implementation and coordination of the FSSP.

4. Referrals to the FSSP shall be made through the Case Management Agency pursuant to Section 8.7202.B.

5. Nothing in these rules and regulations shall be construed as to prohibit or limit services and supports available to a Member with an Intellectual and Developmental Disability or Developmental Delay and their families which are authorized by other state or federal laws.

6. The Case Management Agency, in cooperation with the local FSC, shall ensure that the FSSP is publicized within the designated service area.

7. The Case Management Agency shall develop written policies and procedures for the implementation and ongoing operation of the FSSP, which must be kept on file and made available to the Department or the public, upon request.

8.75587561.B FSSP Family Support Council (FSC)

1. The Case Management Agency shall assist its defined service area to establish and maintain an FSC pursuant to Section 25.5-10-304, C.R.S.

2. The Case Management Agency shall establish an FSC roster that includes the names of Members, type of membership and identifies the chairperson. The roster shall be available to the Department or the public, upon request.

3. Composition of the FSC:

a. The majority of the members and the chairperson of each FSC shall be Family Members of an individual with an Intellectual and Developmental Disabilities or Developmental Delay.

b. New members of the FSC shall be recruited from the service area. New members shall be approved by the current FSC and the governing body of the Case Management Agency.

c. The members of the FSC shall receive written notice of their appointment.

d. The Case Management Agency shall ensure an orientation and necessary training regarding the duties and responsibilities of the FSC is available for all council members. The training and orientation shall be documented with a record of the date of the training, who provided the training, training topic, and names of attendees.

e. The size of the FSC shall be sufficient to meet the intent and functions of the council, but no fewer than five (5) persons, unless approved by the Department.

f. Each FSC shall establish the criteria for tenure of members, selection of new members, the structure of the council and, in conjunction with the Case Management Agency, a process for addressing disputes or disagreements between the FSC and the Case Management Agency. Such processes shall be documented in writing. Processes may include a request for mediation assistance from the Department.

4. The FSC duties include providing guidance and assistance to the Case Management Agency on the following:

a. Overall implementation of the FSSP;

b. Development of the written annual FSSP report for the defined service area, as defined at Section 8.75615~~8~~.K;

c. Development of written procedures describing how families are prioritized for FSSP funding;

d. Development of written policy defining how an emergency fund is established, funded and implemented. The policy must include a definition of a short-term Crisis or emergency and the maximum amount of funds a Family may receive per event and/or year;

e. Provide recommendations on defining the “other” service category within the parameters as defined in this part;

f. Monitor the implementation of the overall services provided in the defined service area; and

g. Provide recommendations on how to assist families who are transitioning out of the FSSP.

8.~~7558~~7561.C FSSP Member Eligibility

1. Any individual with an Intellectual and Developmental Disability or Developmental Delay, as determined pursuant to Section 25.5-10-211, C.R.S., living with their Family is eligible for the FSSP. Living with a Family means that the individual's place of residence is with that family.

a. If an individual is out of the primary residence because of transition into or outr of the home for longer than 6 months, that individual is no longer eligible for FSSP. ~~Living with Family may include periods of time from one (1) day to up to six (6) months during which time the individual is not in his or her primary residence because of transition into or out of the home.~~

b. The Case Management Agency, in cooperation with the local FSC, shall determine what constitutes a transition.

2. The Family and eligible individual shall reside in the State of Colorado.

3. Eligibility for the FSSP does not guarantee the availability of services under this program.

8.~~7558~~7561.D FSSP Direct Services and Inclusions

1. Services and supports available under the FSSP may be purchased from any provider that is able to meet the individual needs of the family. ~~variety of providers who are able to meet the individual needs of the family.~~

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

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

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

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

6. Case Management Agencies shall not charge a separate fee for assisting individuals to access services identified on the FSP.

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

8. Included Direct Services:

a. Assistive technology is equipment or upgrades to equipment, which are necessary for the individual with an Intellectual and Developmental Disability or Developmental Delay to communicate through expressive and receptive communication, move through or manipulate his or her environment, control his or her environment, or remain safe in the family home. Assistive technology includes non-Adaptive Equipment that meets disability-specific needs identified in the Family Support Plan.

b. Environmental engineering is a home or vehicle modification needed due to the individual's disability and is not a regular maintenance or modification needed by all owners. Modifications to the home or vehicle must be:

i. Necessary due to the individual's Intellectual and Developmental Disability or Developmental Delay;

ii. Needed due to health and safety; or

iii. To allow the individual to attain more independence;

~~c~~iv. Modifications must be completed in a cost-effective manner. Cost-effective manner means the least expensive manner to meet the identified need. Home modifications are to be limited to the common areas of the home the individual with an Intellectual and Developmental Disability frequents, the individual's bedroom, and one bathroom. Other bedrooms and bathrooms shall not be modified. All devices and adaptations must be provided in accordance with applicable state or local building codes and/or applicable standards of manufacturing, design, and installation. Only homes or vehicles occupied and owned by the Family where the eligible individual resides may be modified. Minor modifications may be made to rental units with the permission of the landlord. Rental modifications must be made in a way that the modification can be moved with the eligible individual during a change in residence.

~~d~~c. Medical and dental items prescribed by a medical professional licensed and qualified to prescribe such items and are needed to maintain or attain physical health. Medical, dental, and vision services, exams and procedures are available when not covered by another source.

i. Over the counter medications and vitamins are excluded, except as indicated at Section 8.800.4.D, when prescribed by a medical professional licensed and qualified to write such prescriptions.

~~e~~d. Other: Services in this category must be identified in the FSP, are specific to the family, and are limited to:

i. A consultant and/or advocate to assist a Family with accessing services outside of the Case Management Agency.

ii. Recreational needs of the individual with an Intellectual and Developmental Disability or Developmental Delay when the need of recreation is above and beyond the typical need due to the disability or delay. The cost of family recreation passes shall the cost of one family pass per fiscal year and shall be limited to use only at community recreation centers, except in communities where community recreation centers do not exist and in cases where the use of an alternative recreation facility is justified by a need related to the disability or delay, and the activity and/or facility is recommended by a licensed or certified professional qualified to make the recommendation. In such circumstances, the Case Management Agencies shall document the professional recommendation and demonstrate that the chosen facility is the least expensive option to meet the family's needs.

1) The following items are specifically excluded under the FSSP and shall not be eligible for coverage:

a) Entrance fees for:

i) Zoos;

ii) Museums;

iii) Movie theaters, performance theaters, concerts, other entertainment venues; and

iv) Professional and minor league sporting events.

b) Outdoors play structures; and

c) Batteries for recreational items.

iii. Specialized services as identified by the FSC and Case Management Agency included in their written policy and are available to any Family receiving ongoing FSSP assistance in the service area.

~~iv~~e. Parent and sibling support, which may include special resource materials or publications, cost of care for siblings, or behavioral services or counseling.

f~~v~~. Professional services are services which require licensure or certification to treat a human condition other than medical, dental or vision, and is provided to the individual with an Intellectual and Developmental Disability or Developmental Delay. Professional services must be provided by qualified, certified and/or licensed personnel in accordance with the standards and practices of the industry. Professional services may include related support items, equipment, or activities which are recommended as part of the therapy with supporting documentation from the treating professional. Insurance expenses directly incurred by the individual with an Intellectual and Developmental Disability or Developmental Delay are included.

~~vi. Respite is the temporary care of an individual with an Intellectual and Developmental Disability that provides relief to the primary caregiver.~~

~~vii~~g. Program expenses are services related to serving multiple families and are funded through the direct service line.

i~~f~~. This service is not identified in the individual's FSP. This service is provided by the Case Management Agency for the benefit of multiple families.

ii~~g~~. Program expenses are the maintenance, operation, or enhancement of a resource library that consists of an inventory of goods and equipment used to meet the needs of individuals with an Intellectual and Developmental Disability or Developmental Delay on a temporary basis.

iii~~h~~. Program expenses are the costs associated with participation with other community agencies in the development, maintenance, and operation of projects, supports or services that benefit individuals with an Intellectual and Developmental Disability ~~DD~~ or Developmental Delay.

iv~~i~~. Program expenses are the development or coordination of a training event for families.

vj. Program expenses are the costs of an event sponsored by the Case Management Agency for all eligible individuals and their families to meet other families to provide socialization and an opportunity to build a network of support.

vik. Program expenses are the development and coordination of group respite.

viil. The FSC in conjunction with the Case Management Agency shall determine the maximum amount of direct services to be used for program expenses.

h. Respite is the temporary care of an individual with an Intellectual and Developmental Disability that provides relief to the primary caregiver.

~~i. Respite is the temporary care of an individual with an Intellectual and Developmental Disability that provides relief to the family.~~

ii. Transportation is the direct cost to the Family that is higher than costs typically incurred by other families because of specialty medical appointments or therapies. Specialty medical appointments or therapies are defined as appointments needed due to the individual's Intellectual and Developmental Disability or Developmental Delay. The direct cost is the cost of transportation, lodging, food expense, and long-distance telephone calls to arrange for or coordinate medical services which are not covered by other sources.

8.~~75587~~7561.E FSSP Waiting List

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

8.~~75587~~7561.F FSSP Prioritization for Family Support Services (FSSP) Funding

1. Case Management Agencies must ensure that families with the highest assessed needs shall be prioritized for FSSP state funding.
2. Case Management Agencies, in conjunction with the FSC, will develop written procedures that describe how families shall be prioritized and notified of the prioritization process.

3. The Assessment process shall be applied equally and consistently to all families who are assessed.

4. Case Management Agencies must distribute the prioritization process to families in their defined service area at the time the Family requests FSSP funding, when the individual is placed on the waiting list, or upon request.

5. The Case Management Agency must notify families in writing of the results of the Assessment.

6. All families, both on the waiting list and receiving FSSP services, shall be assessed for level of need on an annual basis or earlier if the family's circumstances change.

7. The Assessment must contain the following components:

    a. The qualifying individual's disability and overall care need, which includes:

        i. The type of disability or condition and the need and complexity of medical or personal care for the individual;

        ii. The need for, frequency of, and amount of direct assistance required to care for the individual; and

        iii. The types of services needed that are above and beyond what is typically needed for any individual.

    b. The qualifying individual's behavioral concerns, including how behaviors disrupt or impact the family's daily life, the level of supervision required to keep the individual and others safe, and the services and frequency required to help with the behaviors.

    c. The Family composition, which considers obligations and limitations of the Parent(s), the number of siblings, disabilities of other family members living in the home, and the level of stability of the family, such as pending divorce or age and disability of Parents.

    d. The family's access to support networks, which includes the level of isolation or lack of support networks for the family, such as not having extended family nearby, living in rural areas or availability of providers.

    e. The family's access to resources such as family income, insurance coverage, HCBS waivers, and/or other private or public benefits.

8.~~7558~~7561.G FSSP Case Management Responsibilities

1. Case management is the coordination of services provided for individuals with an Intellectual and Developmental Disability (IDD) or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education, and other services to ensure non-duplication of services, and monitor the effective and efficient provision of services across multiple funding sources.

2. At minimum, the Case Manager is responsible for:

    a. Determining initial and ongoing eligibility for the FSSP;

    b. Development, application assistance, and annual re-evaluation of the Family Support Plan (FSP); and

c. Ensuring service delivery in accordance with the FSP.

3. Family Support Plan Requirements

a. Families enrolled into the FSSP shall have an individualized FSP which meets the requirements of an Individualized Plan, as defined in Sections 25.5-10-202 and 25.5-10-211, C.R.S., and includes the following information:

i. The name of the eligible individual;

ii. The names of Family Members living in the household;

iii. The date the FSP was developed or revised;

iv. The prioritized needs requiring support as identified by the family;

v. The specific type of service or support, how it relates to the Family need and the individual's disability or Developmental Delay, and period which is being committed to in the FSP, including, when applicable, the maximum amount of funds which can be spent for each service or support without amending the FSP;

vi. Documentation regarding cost-effectiveness of a service or support, which can include quotes, bids, or product comparisons but must include the reason for selecting a less cost-effective service or support, when applicable;

vii. A description of the desired results, including who is responsible for completion;

viii. The projected timelines for obtaining the service or support and, as appropriate, the frequency;

ix. A statement of agreement with the plan;

x. Signatures, which may include digital signatures of a family representative and an authorized Case Management Agency representative;

xi. The level of need;

xii. The length of time the funds are available; and

xiii. A description of how payment for the services or supports will be made.

b. The FSP shall integrate with other service plans affecting the Family and avoid, where possible, any unnecessary duplication of services and supports.

c. The FSP shall be reviewed at least annually or on a more frequent basis if the plan is no longer reflective of the family's needs.

i. Any changes to the provision of services and supports identified in the FSP are subject to available funds within the defined service area.

ii. Any decision to modify, reduce or deny services or supports set forth in the FSP, without the family's agreement, are subject to the requirements in Section 8.720~~2~~1.D~~S~~.

4. Emergency Fund

a. Each Case Management Agency shall establish an emergency fund that may be accessed by any individual eligible for the FSSP when needed due to an unexpected event that has a significant impact on the individual or family's health or safety and impacts the family's daily activities.

b. Any individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay determined by the Case Management Agency and living with Family shall be eligible to receive emergency funds regardless of the enrollment status of the family.

c. The Case Management Agency in conjunction with the Family Support Council shall develop written policies and procedures regarding the Emergency Fund. At a minimum the policies and procedures must:

i. Define the purpose of the emergency fund;

ii. Define an unexpected event and significant impact;

iii. Describe the process for accessing emergency funds;

iv. Describe how funding determinations are made;

v. Give a timeline of the determination of the request;

vi. Define the maximum funding amount per Family or per event; and

vii. Describe how families will be notified of the decision in writing.

8.~~7558~~7561.H FSSP Billing and Payment Procedures

1. The Case Management Agency shall develop and implement policies, procedures, and practices for maintaining documentation for the FSSP and reporting information in the format and timeframe established by the Department.

2. Families shall maintain and provide either receipts or invoices to the Case Management Agency documenting how funds provided to the Family through the FSSP were expended. The Case Management Agency shall maintain supporting documentation capable of substantiating all expenditures and reimbursements made to providers and/or families, which shall be made available to the Department upon request.

a. When the Case Management Agency purchases services or items directly for families, the Case Management Agency shall maintain receipts or invoices from the service provider and documentation demonstrating that the provider was paid by the Case Management Agency. Receipts or invoices must contain, at a minimum, Member and/or Family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount due or paid.

b. When the Case Management Agency reimburses families for services or items, the Case Management Agency shall ensure the Family provides the Case Management Agency with receipts or invoices prior to reimbursement. The Case Management Agency shall maintain receipts or invoices from the families, and documentation demonstrating that the Family was reimbursed by the Case Management Agency. The Case Management Agency must ensure all receipts or invoices provided by the families contain, at a minimum, Member and/or Family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

c. When the Case Management Agency provides funding to the families for the purchase of services or items in advance, the Case Management Agency shall notify the families that they are required to submit invoices or receipts to the Case Management Agency of all purchases made prior to the close of the State Fiscal Year. The Case Management Agency must ensure that all receipts or invoices are collected and maintained from the family, as well as documentation demonstrating that the Family received funding from the Case Management Agency. The Case Management Agency must ensure all receipts or invoices provided by the families contain, at a minimum, Member and/or Family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

3. The Case Management Agency shall submit to the Department, on a form and frequency prescribed by the Department, information which outlines individual Family use of the FSSP.

4. The Case Management Agency shall report only FSSP expenditure data in the format and timeframe as designated by the Department.

8.~~7558~~7561.I FSSP Program Evaluation

1. The Case Management Agency, in cooperation with the local Family Support Council, shall be responsible for evaluating the effectiveness of the FSSP within its defined service area on an annual basis.

2. The evaluation may be based upon a Family satisfaction survey and shall address the following areas:

   a. Effectiveness of outreach/public awareness including:

      i. The demographics of participants in comparison to demographics of the service area; and

      ii. How well the program integrates with other community resources.

   b. Satisfaction and program responsiveness to include:

      i. Ease of access to the program;

      ii. Timeliness of services;

      iii. Effectiveness of services;

      iv. Availability of services;

      v. Responsiveness to Family concerns;

      vi. Overall Family satisfaction with services; and

      vii. Recommendations.

   c. Effective coordination and utilization of funds to include:

      i. Other local services and supports utilized in conjunction with the FSSP; and

      ii. Efficiency of required documentation for receipt of the FSSP.

d. The Case Management Agency, and participating families as requested, shall cooperate with the Department regarding statewide evaluation and quality assurance activities, which includes, but is not limited to providing the following information:

i. The maximum amount any one Family may receive through the FSSP during the fiscal year; and

ii. The total number of families to be served during the year.

8.~~7558~~7561.J FSSP Performance and Quality Review

1. The Department shall conduct a Performance and Quality Review of the FSSP to ensure that it complies with the requirements set forth in these rules.

2. A Case Management Agency found to be out of compliance with these rules through the results of the Performance and Quality Review, shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the receipt of the written request from the Department. A Corrective Action Plan shall include, but not limited to:

a. A detailed description of the action to be taken, including any supporting documentation;

b. A detailed time frame specifying the actions to be taken;

c. Employee(s) responsible for implementing the actions; and

d. The implementation timeframes and a date for completion.

3. The Case Management Agency shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The Agency shall explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the Agency's compliance.

a. Upon receipt of the Corrective Action Plan, the Department will accept, modify or reject the proposed Corrective Action Plan. Modifications and rejections shall be accompanied by a written explanation.

b. In the event that the Corrective Action Plan is rejected, the Agency shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

c. The Agency shall implement the Corrective Action Plan upon acceptance by the Department.

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

8.~~7558~~7561.K FSSP Annual Report

1. Each Case Management Agency shall submit an annual FSSP report to the Department by October 1 of each year. The report will contain two sections.

a. The first section must describe how the Case Management Agency plans to spend the FSSP funds in the current fiscal year and will include:

i. Description of the outreach/public awareness efforts for the coming year;

ii. Description of anticipated special projects or activities under the Program Expense service category; and

iii. Goals with measurable outcomes for any changes to the FSSP.

b. The second section of the annual report will describe how the FSSP funds were spent in the previous year and must contain:

i. The program evaluation outcomes for the previous year as described in this section;

ii. The total amount of funds expended by service category;

iii. The total number of families served, and the total number of families placed on the waiting list;

iv. Detailed information for the Program Expense service category to include:

1) The total number of families that utilized services under the Program Expense category;

2) The specific services provided; resource library, special projects, training events, social events, or group respite;

3) How these services enhanced the lives of families in the community and the total number of families who participated in each project; and

4) The report shall include the total number of staff, total of staff cost, and other costs associated with the Program Expense service category.

v. A description of how the annual FSSP report was distributed to eligible families; and

vi. The signature of Family Support Council (FSC) members, the FSSP Coordinator, and the Case Management Agency Executive Director.

8.~~7559~~7562 HCBS Telehealth Delivery

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

8.~~7559~~7562.A HCBS Telehealth Inclusions

1. HCBS Telehealth may be used to deliver support through the following authorized HCBS Waiver Services:

a. Adult Day Services; defined at Section 8.75054;

b. Behavioral Management and Education; defined at Section 8.75087;

c. Behavioral Therapies - Behavioral Consultation; defined in Section 8.75089;

d. Behavioral Therapies - Behavioral Counseling, Group, defined in Section 8.75089;

e. Behavioral Therapies - Behavioral Counseling, Individual, defined in Section 8.75089;

f. Behavioral Therapies - Behavioral Plan Assessment; defined in Section 8.75089;

g. Bereavement Counseling; defined at Section 8.75110;

h. Child and Youth Mentorship; defined at Section 8.75121;

i. Community Connector; defined at Section 8.75134;

j. Counseling Services, Family; defined at Section 8.75156;

k. Counseling Services, Group; set forth at Section 8.75156;

l. Counseling Services, Individual; set forth at Section 8.75165;

m. Day Habilitation; described at Section 8.75176;

n. Expressive Therapy - Art and Play Therapy, Group; defined at Section 8.75210;

o. Expressive Therapy - Art and Play Therapy, Individual; defined at Section 8.75210;

p. Expressive Therapy - Music Therapy, Group; defined at Section 8.75210;

q. Expressive Therapy - Music Therapy, Individual; defined at Section 8.75210;

r. Independent Living Skills Training; defined at Section 8.75298;

s. Mentorship; defined at Section 8.75343;

t. Movement Therapy; defined in Section 8.75342;

u. Palliative/Supportive Care; defined at Section 8.75364;

v. Substance Use Counseling, Family; defined at Section 8.75485;

w. Substance Use Counseling, Individual; defined at Section 8.75485;

x. Supported Employment - Job Coaching, Individual, defined in Section 8.75496;

y. Supported Employment - Job Development, Levels 1-6, Individual, defined at Section 8.75496;

z. Life Skills Training; described at Section 8.753029;

aa. Peer Mentorship; defined at Section 8.75375;

bb. Therapeutic Life Limiting Illness Support, Family; defined at Section 8.755148;

cc. Therapeutic Life Limiting Illness Support, Group; defined at Section 8.755148;

dd. Therapeutic Life Limiting Illness Support, Individual; defined at Section 8.755148; and

ee. Wraparound Services - Wraparound Plan and Prevention and Monitoring; defined at Section 8.75574.

2. HCBS Telehealth may only be used to deliver consultation for the following services:

a. Adaptive Therapeutic Recreational Fees and Equipment, described at Section 8.75034;

b. Assistive Technology; defined in Section 8.75067

c. Home Accessibility Modifications and Adaptations; defined in Section 8.752~~4~~5 and

d. Vehicle Modifications, defined in Section 8.755~~4~~1.

e. Providers shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules and may not bill separately for consultation.

8.~~7559~~7562.B HCBS Telehealth Exclusions and Limitations

1. HCBS Telehealth is subject to the limitations of the respective service it supports as referenced in this rule at Section 8.756~~259~~.A.

2. HCBS Telehealth is not a duplication of Health First Colorado Telehealth or Telemedicine services.

3. HCBS Telehealth is not permitted to be used for any service not listed in this rule at Section 8.756~~259~~.A.

8.~~7559~~7562.C HCBS Telehealth Provider Agency Requirements

1. Providers that choose to use HCBS Telehealth shall develop and make available a written HCBS Telehealth Policy which at a minimum shall include the following:

   a. The Member may refuse telehealth delivery at any time without affecting the Member's right to any future services and without risking the loss or withdrawal of any service to which the Member would otherwise be entitled;

   b. All required and applicable confidentiality protections that apply to the services;

   c. The Member shall have access to all collected information resulting from the services utilized as required by state law;

   d. How utilization of HCBS Telehealth will be made available to those Members who require assistance with accessibility, translation, or have limited visual and/or auditory capabilities;

   e. A contingency plan for service delivery if technology options fail; and,

   f. Provider Agencies shall maintain a copy of the HCBS Telehealth Policy signed by the Member in their records.

2. Provider Agencies shall ensure the use of HCBS Telehealth is the choice of the Member. The HCBS ~~waiver p~~Provider Agency shall maintain a consent form for the use of HCBS Telehealth in the Member's record.

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

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

5. Provider Agencies shall not use HCBS Telehealth to address a Member's emergency needs.

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

8.~~7559~~7562.D HCBS Telehealth Reimbursement

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

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