**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

**Medical Services Board**

**MEDICAL ASSISTANCE - SECTION 8.500 HCB-DD, CES, Oxygen, DME**

**10 CCR 2505-10 8.500**

*[Editor's Notes follow the text of the rules at the end of this CCR Document.]*

---

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

**8.500.1** This Section hereby incorporates the terms and provisions of the federally approved Home and Community-based Services for Individuals with Intellectual or Developmental Disabilities (HCBS-DD) waiver. To the extent that the terms of that federally approved waiver are inconsistent with the provisions of this Section, the waiver will control.

### 8.500.1 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD waiver or a HCBS waiver service.

C. APPLICANT means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. AUDITABLE means the information represented on the wavier cost report can be verified by reference to adequate documentation as required by generally accepted auditing standards.

E. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client 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) as defined at Section 8.510.1.

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

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

H. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

I. COMMUNITY CENTERED BOARD means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

J. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing home and community-based services and Medicaid state plan benefits including long-term home health services and targeted case management.

K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

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

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means as defined in 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and is defined as:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a Client with an intellectual or developmental disability has been given by a court; or,

A spouse; or,

The Client's children.

Q. FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for long term services and supports as determined by the Department's prescribed instrument.

R. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long-term Care instrument and medical verification on the Professional Medical Information Page to determine if the Client meets the institutional Level of Care (LOC).

S. GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) Clients receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment as a residential care facility or residential community home for persons with developmental disabilities.

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

U. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

V. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IDD)

W. INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation services provided to three (3) or fewer Clients in a single residential setting or in a host home setting that does not require licensure by the Colorado Department of Public Health and Environment.

X. INSTITUTION means a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IDD) for which the Department makes Medicaid payment under the Medicaid State Plan.

Y. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately-operated facility that provides health and habilitation services to a Client with an intellectual or developmental disability or related conditions.

Z. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.

AA. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

BB. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

CC. MEDICAID ELIGIBILE means an applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

DD. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

EE. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

FF. NATURAL SUPPORTS means non-paid informal relationships that provide assistance and occur in the Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

GG. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

HH. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent or the Case Management Agency.

II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to certify the client's medical necessity for long-term care services.

JJ. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined Section 8.600.4 et seq., that has received program approval to provide HCBS-DD waiver services.

KK. PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use, including vehicles for hire.

LL. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

MM. RETROSPECTIVE REVIEW means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the support plan and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

NN. SERVICE PLAN means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.

OO. STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER means the state owned and operated agency providing HCBS waiver services to Clients enrolled in the HCBS-DD waiver.

PP. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

QQ. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

RR. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

SS. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. That may include, but are not limited to, community resources, services provided through private insurance, non-profit services and other government programs.

TT. WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

**8.500.2 HCBS-DD WAIVER ADMINISTRATION**

8.500.2.A HCBS-DD shall be provided in accordance with the federally approved waiver document and these rules and regulations.

8.500.2.B The HCBS-DD waiver provides the necessary support to meet the daily living needs of a Client who requires access to 24-hour support in a community-based residential setting.

8.500.2.C HCBS-DD Waiver services are available only to address those needs identified in the functional needs assessment and authorized in the service plan and when the service or support is not available through the Medicaid state plan, EPSDT, natural supports or third-party resources.

8.500.2.D THE HCBS-DD WAIVER:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments do not to exceed the federally approved capacity, and

4. May limit the enrollment when utilization of the HCBS-DD Waiver program is projected to exceed the spending authority.

**8.500.3 GENERAL PROVISIONS**

8.500.3.A The following provisions shall apply to the HCBS-DD waiver.

1. HCBS-DD waiver services shall be provided as an alternative to ICF-IID services for a Client with intellectual or developmental disabilities.

2. HCBS-DD is waived from the requirements of Section 1902(a)(10)(B) of the Social Security Act concerning comparability of services. The availability of some services may not be consistent throughout the State of Colorado.0

3. A Client enrolled in the HCBS-DD waiver shall be eligible for all other Medicaid services for which the Client qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-DD waiver. Services received through the HCBS-DD waiver may not duplicate services available through the state plan.

**8.500.4 CLIENT ELIGIBILITY**

8.500.4.A To be eligible for the HCBS-DD waiver, an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability,

2. Be eighteen (18) years of age or older,

3. Require access to services and supports twenty-four (24) hours a day,

4. Meet ICF-IID level of care as determined by the functional needs assessment, and

5. Meet the Medicaid financial determination for LTC eligibility as specified in Section 8.100, *et seq*.

8.500.4.B The Client shall maintain eligibility by meeting the criteria as set forth in Section 8.500.6.A.1 and .2 and the following:

1. Receives at least one (1) HCBS waiver service each calendar month.

2. Is not simultaneously enrolled in any other HCBS waiver.

3. Is not residing in a hospital, nursing facility, ICF-IID, correctional facility or other institution.

4. Is served safely in the community with the type and amount of waiver services available and within the federally approved capacity and cost containment limits of the waiver.

5. Resides in a GRSS or IRSS setting.

8.500.4.C When the HCBS-DD Waiver reaches capacity for enrollment, a Client determined eligible for the waiver shall be eligible for placement on a wait list in accordance with these rules at Section 8.500.7.

**8.500.5 HCBS-DD WAIVER SERVICES**

**8.500.5.A SERVICES PROVIDED**

1. Behavioral Services

2. Day Habilitation Services and Supports

3. Dental Services

4. Home Delivered Meals

5. Non-Medical Transportation

6. Peer Mentorship

7. Residential Habilitation Services and Supports (RHSS)

8. Specialized Medical Equipment and Supplies

9. Supported Employment

10. Transition Setup

11. Vision Services

**8.500.5.B DEFINITIONS OF SERVICES**

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

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

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

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

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

    d. Behavioral Services include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i) Include the opportunity for Clients to select from Age Appropriate Activities and Materials, as defined in Section 8.484.2.A., both within and outside of the setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Preventative services include:

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

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv). Non-intravenous sedation,

v) Basic and deep cleanings,

vi). Mouth guards,

vii) Topical fluoride treatment, and

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

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

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

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth

c. Major services include:

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

ii) Crowns

iii) Bridges

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

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

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

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

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

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

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

4. Home Delivered Meals as defined at Section 8.553.1.

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

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

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

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

6. Peer Mentorship as defined at Section 8.553.1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Specialized Medical Equipment and Supplies include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Transition Setup services as defined at Section 8.553.1.

11. Vision Services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a Client who is at least twenty-one (21) years of age.

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

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

ii) Prior authorized in accordance with Operating Agency procedures.

**8.500.6 SERVICE PLAN**

8.500.6.A The Case Management Agency shall complete a Service Plan for each Client enrolled in the HCBS-DD waiver in accordance with Section 8.519.11.B.2.

8.500.6.D The Service Plan must be reported in the Department prescribed system and include the following employment information for individuals eligible for or receiving Supported Employment services, if applicable:

1. Sector and type of employment;

2. Mean wage per hour earned; and

3. Mean hours worked per week.

**8.500.7 WAITING LIST PROTOCOL**

8.500.7.A There shall be one waiting list for persons eligible for the HCBS-DD waiver when the total capacity for enrollment or the total appropriation by the general assembly has been met.

8.500.7.B The name of a person eligible for the HCBS-DD waiver program shall be placed on the waiting list by the community centered board making the eligibility determination.

8.500.7.C When an eligible person is placed on the waiting list for HCBS-DD waiver services, a written notice of action including information regarding Client rights and appeals shall be sent to the person or the person's legal guardian in accordance with the provisions of Section 8.057 *et seq*.

8.500.7.D The placement date used to establish a person's order on a waiting list shall be:

1. The date on which the person was initially determined to have a developmental disability by the community centered board; or

2. The fourteenth (14) birth date if a child is determined to have a developmental disability by the community centered board prior to the age of fourteen.

8.500.7.E As openings become available in the HCBS-DD Waiver program in a designated service area, that community centered board shall report that opening to the Operating Agency.

8.500.7.F Persons whose name is on the waiting list shall be considered for enrollment to the HCBS-DD waiver in order of placement date on the waiting list. Exceptions to this requirement shall be limited to:

1. An emergency situation where the health and safety of the person or others is endangered, and the emergency cannot be resolved in another way. Persons at risk of experiencing an emergency are defined by the following criteria:

   a. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; or whose primary residence during the night is a public or private facility that provides temporary living accommodations; or any other unstable or non-permanent situation; or is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

   b. Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in the person’s present living situation and the person’s health, safety or well-being is in serious jeopardy.

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

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

   e. Loss or Incapacitation of Primary Caregiver: a person’s primary caregiver is no longer in the person’s primary residence to provide care; or the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or 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.

8.500.7.G Enrollments may be reserved to meet statewide priorities that may include:

1. A person who is eligible for the HCBS-DD Waiver and is no longer eligible for services in the foster care system due to an age that exceeds the foster care system limits,

2. Persons who reside in long-term care institutional settings who are eligible for the HCBS-DD Waiver and have a requested to be placed in a community setting, and

3. Persons who are in an emergency situation.

8.500.7.H Enrollments shall be authorized to persons based on the criteria set forth by the general assembly in appropriations when applicable.

8. 500.7.I. A person shall accept or decline the offer of enrollment within thirty (30) calendar days from the date the enrollment was offered. Reasonable effort shall be made to contact the person, family, legal guardian, or other interested party.

1. Upon a written request of the person, family, legal guardian, or other interested party an additional thirty (30) calendar days may be granted to accept or decline an enrollment offer.

2. If a person does not respond to the offer of enrollment within the allotted time, the offer is considered declined and the person will maintain their order of placement date.

**8.500.8 CLIENT RESPONSIBILITIES**

8.500.8.A A Client or guardian is responsible to:

1. Provide accurate information regarding the Client's ability to complete activities of daily living,

2. Assist in promoting the Client's independence,

3. Cooperate in the determination of financial eligibility for Medicaid,

4. Notify the case manager within thirty (30) days after:

a. Changes in the Client's support system, medical, physical or psychological condition or living situation including any hospitalizations, emergency room admissions, placement to a nursing home or ICF-IID,

b. The Client has not received an HCBS waiver service during one (1) month,

c. Changes in the Client's care needs,

d. Problems with receiving HCBS waiver services,

e. Changes that may affect Medicaid financial eligibility including prompt reporting of changes in income or assets.

**8.500.9 PROVIDER REQUIREMENTS**

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

1. Conform to all state established standards for the specific services they provide under HCBS-DD,

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in Section 8.130,

4. Discontinue services to a Client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services,

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

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

7. Maintain Client records to substantiate claims for reimbursement according to Medicaid standards.

8. HCBS-DD providers shall comply with:

   a. All applicable provisions of Title 27 Article10.5, C.R.S., and all rules and regulations as set forth in 2 CCR 503-1, Section 16.

   b. All federal program reviews and financial audits of the HCBS-DD waiver services,

   c. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,

   d. Requests from the County Departments of Social/Human Services to access records of Clients receiving services held by Case Management Agencies as required to determine and re-determine Medicaid eligibility

   e. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-DD waiver, and

   f. Requests by the Case Management Agency to monitor service delivery through targeted case management activities..

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

   a. Subject to the availability of appropriations for reimbursement in section 8.500.14.H. Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

      i. Deadlines.

1) Existing staff, employed by the Provider on or before July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

2) Newly hired staff, employed by the Provider after July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

a) 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.

ii. Department approval required.

1) The Training Certificate or Certification required under section 8.500.9.B.1.a must be pre-approved by the Department.

a) Providers 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) Seeking approval for:

1) Training Certificate, or

2) Certification, or

3) Training Certificate and Certification.

iv) Name 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) Name 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:

1) Whether a certificate of completion is received.

vii) Date of Certification exam, if applicable.

b) Department approval will be based on alignment with the following core competencies:

i) Core values and principles of Supported Employment, including the following:

1) The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.

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 Clients 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 Clients with significant disabilities, which meets the needs of both the employer and the Client.

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 8.500.9.B.1.a.ii.1.a.

**8.500.10 TERMINATION OR DENIAL OF HCBS-DD MEDICAID PROVIDER AGREEMENTS**

8.500.10.A The Department may deny or terminate an HCBS-DD Medicaid Provider Agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq.*

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-DD services.

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior client notification.

5. The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with the procedures at 10 CCR 2505-10, Section 8.050.

**8.500.11 ORGANIZED HEALTH CARE DELIVERY SYSTEM**

8.500.11.A The Organized Health Care Delivery System (OHCDS) for the HCBS-DD Waiver is the Community Centered Board as designated by the Operating Agency in accordance with § 27-10.5-103 C.R.S..

8.500.11.B The OHCDS is the Medicaid provider of record for a client whose services are delivered through the OHCDS.

8.500.11.C The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS according to the current federally approved waiver.

8.500.11.D The OHCDS may contract or employ for delivery of HCBS waiver services.

8.500.11.E The OCHDS shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS waiver,

2. Ensure that services are delivered according to the waiver definitions and as identified in the client's service plan,

3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

4. Monitor the health and safety for HCBS clients receiving services from a subcontractor.

8.500.11.F The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients,

4. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and Operating Agency procedures,

a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

5. Collect and maintain the data used to develop provider rates and ensure that the data includes costs for services to address the client's needs, that are allowable activities within the HCBS service definition and that supports the established rate,

6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency or Centers for Medicare and Medicaid Services (CMS), and

7. Report by August 31st of each year, the names, rates and total payments made to the contractor.

**8.500.12 PRIOR AUTHORIZATION REQUESTS**

8.500.12.A Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14.

**8.500.13 RETROSPECTIVE REVIEW PROCESS**

8.500.13.A Services provided to a Client are subject to a Retrospective Review by the Department and the Operating Agency. This Retrospective Review shall ensure that services:

1. Identified in the service plan are based on the Client's identified needs as stated in the functional needs assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a Client are in accordance with the service plan, and

4. Provided within the specified HCBS service definition in the federally approved HCBS-DD waiver,

8.500.13.B When the retrospective review identifies areas of noncompliance, the Case Management Agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.13.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.500.13.D When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

**8.500.14 PROVIDER REIMBURSEMENT**

8.500.14.A Providers shall submit claims directly to the Department's Fiscal Agent through the Medicaid Management Information System (MMIS); or through a qualified billing agent enrolled with the Department's Fiscal Agent.

8.500.14.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally-approved HCBS-DD waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the Client's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.14.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.14.D When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.14.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.14.F For private providers payment is based on a statewide fee schedule.

8.500.14.G Reimbursement paid to State or local government HCBS waiver providers differs from the amount paid to private providers of the same service. No public provider may receive payments in the aggregate that exceed its actual costs of providing HCBS waiver services.

1. Reimbursement paid to State and local government HCBS waiver providers shall not exceed actual costs. All State and local HCBS waiver providers must submit an annual cost report for HCBS waiver services.

2. Actual costs will be determined on the basis of the information on the HCBS waiver cost report and obtained by the Department or its designee for the purposes of cost auditing.

    a. The costs submitted by the provider for the most recent available final cost report for a 12-month period shall be used to determine the interim rates for the ensuing 12 month period effective July 1 of each year.

        i. The interim rate will be calculated as total reported costs divided by total units per HCBS waiver service.

        ii. An interim rate shall be determined for each HCBS waiver service provided.

        iii. The most recent available final cost report will be used to set the next fiscal year's interim rates.

b. Reimbursement to State and local government HCBS waiver providers shall be adjusted retroactively after the close of each 12-month period.

c. Total costs submitted by the provider shall be reviewed by the Department or its designee and result in a total allowable cost.

d. The Department will determine the total interim payment through the MMIS.

e. The Department will reconcile interim payments to the total allowable and make adjustments to payments as necessary. Interim payments shall be paid through the MMIS.

3. Submission of the HCBS waiver cost report shall occur annually for costs incurred during the prior fiscal year.

a. The cost report for HCBS waiver services must be submitted to the Department annually on October 31 to reflect costs from July 1-June 30.

b. The cost report will determine the final adjustment to payment for the period for which the costs were reported.

c. Reconciliation to align the fiscal year reimbursement with actual fiscal year costs after the close of each fiscal year shall be determined by the Department annually.

e. A State or local government HCBS waiver provider may request an extension of time to submit the cost report. The request for extension shall:

i. Be in writing and shall be submitted to the Department.

ii. Document the reason for failure to comply.

iii. Be submitted no later than ten (10) working days prior to the due date for submission of the cost report.

f. Failure of a State or local government HCBS waiver provider to submit the HCBS waiver cost report by October 31 shall result in the Department withholding all warrants not yet released to the provider as described below:

i. When a State or local government HCBS waiver provider fails to submit a complete and auditable HCBS waiver cost report on time, the HCBS waiver cost report shall be returned to the facility with written notification that it is unacceptable.

1. The State or local government HCBS waiver provider shall have either 30 days from the date of the notice or until the end of the cost report submission period, whichever is later, to submit a corrected HCBS waiver cost report.

2. If the corrected HCBS waiver cost report is still determined to be incomplete or un-auditable, the State or local government HCBS waiver provider shall be given written notification that it shall, at its own expense submit a HCBS waiver cost report prepared by a Certified Public Accountant (CPA). The CPA shall certify that the report is in compliance with all Department rules and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

3. The Department may withhold all warrants not yet released to the provider when the original cost report submission period and 30-day extension have expired and an auditable HCBS waiver cost report has not been submitted.

ii. If the audit of the HCBS waiver cost report is delayed by the state or local government HCBS waiver provider's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall mean failure to provide documents, personnel or other resources within its control and necessary for the completion of the audit.

4. Non-allowable costs for State and local government providers offering HCBS waiver services include:

a. Room and Board;

b. Costs which have been allocated to an ICF/IID;

c. Costs for which there is either no supporting documentation or for which the supporting documentation is not sufficient to validate the costs;

d. Costs for services that are available through the Medicaid State Plan or provided on an HCBS waiver other than the HCBS-DD waiver ;

e. Costs for services that are not authorized on an approved HCBS-DD waiver PAR.

f. Costs for services that are not authorized by the Department as an HCBS waiver service;

g. Costs which are not reasonable, necessary, and Client related.

5. Adjustment(s) to the HCBS waiver cost report shall be made by the Department's contract auditor to remove reported costs that are non-allowable.

a. Following the completion of an audit of the cost report the Department or its contract auditor shall notify the affected State or local government HCBS waiver provider of any proposed adjustment(s) to the costs reported on the HCBS waiver cost report and include the basis of the proposed adjustment(s).

b. The provider may submit additional documentation in response to a proposed adjustment. The Department or its contract auditor must receive the additional documentation or other supporting information from the provider within 14 calendar days of the date of the proposed adjustments letter or the documentation will not be considered.

c. The Department may grant a reasonable period, no longer than 30 calendar days, for the provider to submit such documents and information, when necessary and appropriate, given the providers' particular circumstances.

d. The Department or its contract auditor shall complete the audit of the cost report within 30 days of the submission of documentation by the provider.

8.500.14.H Reimbursement for a Supported Employment Training Certificate or Certification, or both, under section 8.500.9.B.1.a, 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 Providers for such costs.

1. Providers seeking reimbursement for completed training or certification, or both, approved under section 8.500.9.B.1.a.ii, must submit the following to the Department:

a. Supported Employment Providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving a reimbursement request under section 8.500.14.H.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under section 8.500.9.B.1.a.ii.1.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.

**8.500.15 INDIVIDUAL RIGHTS**

8.500.15.A Individual rights shall be in accordance with Sections 25.5-10-223 - 230., C.R.S.

**8.500.16 APPEAL RIGHTS**

The Case Management Agency shall meet the requirements set forth at Section 8.519.22.

8.500.16.A The CCB shall provide the long-term care notice of action form to applicants and Clients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq.* When:

1. The Client or applicant is determined to not have a developmental disability,

2. The Client or applicant is found eligible or ineligible for LTSS,

3. The Client or applicant is determined eligible or ineligible for placement on a waiting list for LTSS,

4. An adverse action occurs that affects the Client's or applicant's waiver enrollment status,

8.500.16.B The CCB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CCB has made a denial or adverse action against a Client.

8.500.16.C The CCB shall notify the Case Management Agency in the Client's service plan within one (1) business day of the adverse action.

8.500.16.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.16.E The applicant or Client shall be informed of an adverse action if the Client or applicant is determined ineligible and the following:

1. The Client or applicant is detained or resides in a correctional facility, or

2. The Client or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

**8.500.17 QUALITY ASSURANCE**

8.500.17.A The monitoring HCBS-DD Waiver services and the health and well-being of service recipients shall be the responsibility of the Operating Agency, under the oversight of the Department.

8.500.17.B The Operating Agency, shall conduct reviews of each agency providing HCBS-DD waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department or Operating Agency. The review shall apply rules and standards developed for programs serving individuals with intellectual or developmental disabilities.

8.500.17.C The Operating Agency shall maintain or cause to be maintained for three years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-DD waiver programs or the delivery of services. The Department shall have access to these records at any reasonable time.

8.500.17.D The Operating Agency shall recommend to the Department the suspension of payment, denial or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond by submitting a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.17.E After having received the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action within a reasonable timeframe agreed upon the Department and the Operating Agency.

## 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.

## 8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community-Based Supported Living Services (HCBS-SLS) waiver. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

HCBS-SLS services and supports which are available to assist persons with intellectual or developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an HCBS-SLS setting. HCBS-SLS waiver services are not intended to provide twenty-four (24) hours of paid support or meet all identified Client needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-SLS waiver or a specific HCBS-SLS waiver service(s).

C. APPLICANT means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service 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) as defined at Section 8.510.1.

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

F. CLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

G. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client’s behalf. A Client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or, (B) an individual, family member or friend selected by the Client to speak for and/or act on the Client’s behalf.

H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

I CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

J. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-Based Services, and Medicaid State Plan Benefits including long-term home health services, and targeted case management.

K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

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

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and includes the following:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a Client with an intellectual ordevelopmental disability has been given by a court; or,

A spouse; or

The Client’s children.

Q. FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for long-term services and supports as determined by the Department’ s prescribed instrument.

R. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long-term Care instrument and medical verification on the professional medical information page to determine if the applicant or Client meets the institutional Level of Care (LOC).

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

T. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the “School Attendance Law of 1963,” set forth in Article 33 of Title 22, C.R.S.

U. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

V. INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) for which the Department makes Medicaid payment under the Medicaid State Plan.

W. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a public or private facility that provides health and habilitation services to a Client with intellectual or developmental disabilities or related conditions.

X. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.

Y. LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a Client must require in order to receive services in an institutional setting under the state plan.

Z. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illness who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

AA. MEDICAID ELIGIBLE means an applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

BB. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the State covers, and how the State addresses additional Federal Medicaid statutory requirements concerning the operation of its Medicaid program.

CC. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

DD. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in a Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

EE. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), Home and Community-Based Services Supported Living Services (HCBS-SLS) and Home and Community-Based Services Children's Extensive Support (HCBS-CES) waivers.

FF. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent or the Case Management Agency.

GG. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to certify the Applicant's or Client's need for long-term care services.

HH. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received program approval to provide HCBS-SLS services.

II. PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use including vehicles for hire.

JJ. REIMBURSMENT RATES means the maximum allowable Medicaid reimbursement to a provider for each unit of service.

KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the Client received services according to the service plan and that the Case Management Agency complied with requirements set forth in statute, waiver and regulation.

MM. SERVICE DELIVERY OPTION means the method by which direct services are provided for a Client and include a) by an agency and b) Client directed.

NN. SERVICE PLAN means the written document that specifies identified and needed services to include Medicaid eligible and non-Medicaid eligible services, regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.

OO. SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

PP. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

QQ. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi- structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

RR. SUPPORT LEVEL means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

SS. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

TT. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid that may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

UU. WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State plan benefits.

**8.500.91 HCBS-SLS WAIVER ADMINISTRATION**

8.500.91.A HCBS-SLS shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities, 2 CCR 503-1 and promulgated in accordance with the provision of Section 25.5-6-404 (4), C.R.S.

8.500.91.B In the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the provisions of Section 25.5-6-404(4), C.R.S. shall apply and the regulations of the Department shall control.

8.500.10.C The HCBS-SLS waiver is operated by the the Department of Health Care Policy and Financing.

8.500.910.E HCBS-SLS services are available only to address those needs identified in the functional needs assessment and authorized in the service plan when the service or support is not available through the Medicaid State plan, EPSDT, natural supports, or third party payment resources.

8.500.91.F The HCBS-SLS Waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments into the HCBS-SLS waiver do not exceed the federally approved waiver capacity, and

4. May limit the enrollment when utilization of the HCBS-SLS waiver program is projected to exceed the spending authority.

**8.500.92 GENERAL PROVISIONS**

8.500.92.A The following provisions shall apply to the Home and Community-Based Services-Supported Living Services (HCBS-SLS) waiver:

1. HCBS-SLS shall be provided as an alternative to ICF-IID services for an eligible Client with intellectual or developmental disabilities.

2. HCBS-SLS is waived from the requirements of Section 1902 (a)(10)(b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the State of Colorado.

3. A Client enrolled in the HCBS-SLS waiver shall be eligible for all other Medicaid services for which the Client qualifies and shall first access all benefits available under the Medicaid State plan or Medicaid EPSDT prior to accessing services under the HCBS-SLS waiver. Services received through the HCBS-SLS waiver may not duplicate services available through the State Plan

**8.500.93 CLIENT ELIGIBILITY**

8.500.93.A To be eligible for the HCBS-SLS waiver an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability

2. Be eighteen (18) years of age or older,

3. Does not require twenty-four (24) hour supervision on a continuous basis which is reimbursed as a HCBS-SLS service,

4. Is served safely in the community with the type or amount of HCBS-SLS waiver services available and within the federally approved capacity and cost containment limits of the waiver,

5. Meet ICF-IID level of care as determined by the Functional Needs Assessment

6. Meet the Medicaid financial determination for LTC eligibility as specified at Section 8.100 ; and,

7. Reside in an eligible HCBS-SLS setting. SLS settings are the Client's residence, which is defined as the following:

    a. A living arrangement, which the Client owns, rents or leases in own name,

    b. The home where the Client lives with the Client’s family or legal guardian, or

    c. A living arrangement of no more than three (3) persons receiving HCBS-SLS residing in one household, unless they are all members of the same family.

8. The Client shall maintain eligibility by continuing to meet the HCBS-SLS eligibility requirements and the following:

    a. Receives at least one (1) HCB-SLS waiver service each calendar month,

    b. Is not simultaneously enrolled in any other HCBS waiver, and

    c. Is not residing in a hospital, nursing facility, ICF-IID, correctional facility or other institution.

9. When the HCBS-SLS waiver reaches capacity for enrollment, a Client determined eligible for a waiver shall be placed on a wait list in accordance with these rules at Section 8.500.96.

**8.500.94 HCBS-SLS WAIVER SERVICES**

8.500.94.A. SERVICES PROVIDED

1. Assistive Technology
2. Behavioral Services
3. Day Habilitation services and supports
4. Dental Services
5. Health Maintenance
6. Home Accessibility Adaptations
7. Home Delivered Meals
8. Homemaker Services
9. Life Skills Training (LST)
10. Mentorship
11. Non-Medical Transportation
12. Peer Mentorship
13. Personal Care
14. Personal Emergency Response System (PERS)
15. Professional Services, defined below in 8.500.94.B.14
16. Respite
17. Remote Supports
18. Specialized Medical Equipment and Supplies
19. Supported Employment
20. Transition Setup
21. Vehicle Modifications
22. Vision Services

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

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

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

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

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

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

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

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

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

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

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

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

    i) Purchase, training or maintenance of service animals,

    ii) Computers,

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

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

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

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

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

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

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

d. Behavioral Services:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i) Include the opportunity for Clients to select from Age Appropriate Activities and Materials, as defined in Section 8.484.2.A., both within and outside of the setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Preventative services include:

i) Dental insurance premiums and co-payments

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

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

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

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

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

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

ii) Crowns

iii) Bridges

iv) Dentures

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

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

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

g. Full mouth implants or crowns are not covered.

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

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

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

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

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

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

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

    c. Mouth care performed when:

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

        ii) in the presence of communicable disease,

        iii) the Client is unconscious, or

        iv) oral suctioning is required,

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

    e. Feeding

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

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

        iii) Syringe feeding, OR

        iv) Feeding using an apparatus,

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

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

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

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

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

k. Respiratory care, including:

i. Postural drainage,

ii) Cupping,

iii) Adjusting oxygen flow within established parameters,

iv) Suctioning of mouth and nose,

v) Nebulizers,

vi) Ventilator and tracheostomy care,

vii) Prescribed respiratory equipment.

8.500.94.B.6. HOME ACCESSIBILITY ADAPTATIONS

**8.500.94.B.6.a DEFINITIONS**

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

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

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

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

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

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

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

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

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

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

**8.500.94.B.6.b INCLUSIONS**

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

a) Installing or building ramps;

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

c) Widening or modification of doorways;

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

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

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

g) Installing stair lifts or vertical platform lifts;

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

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

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

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

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

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

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

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

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

ii) Either:

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

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

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

**8.500.94.B.6.c. EXCEPTIONS AND RESTRICTIONS**

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

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

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

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

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

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

ii) configure a bathroom to accommodate a wheelchair.

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

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

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

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

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

a) Roof repair,

b) Central air conditioning,

c) Air duct cleaning,

d) Whole house humidifiers,

e) Whole house air purifiers,

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

g) Monthly or ongoing home security monitoring fees,

h) Home furnishings of any type,

i) HOA fees.

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

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

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

**8.500.94.B.6.d CASE MANAGEMENT AGENCY RESPONSIBILITIES**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    a) Description of the work to be completed,

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

    c) Estimate for building permits, if needed,

    d) Estimated timeline for completing the project,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**8.500.94.B.6.e PROVIDER RESPONSIBILITIES**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**8.500.94.B.6.f REIMBURSEMENT**

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

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

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

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

2) Required permits;

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

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

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

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

c) Approval by the homeowner or property manager;;

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

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

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

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

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

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

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

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

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

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

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

7. Home Delivered Meals as defined at Section 8.553.1.

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

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

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

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

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

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

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

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

2) To increase the independence of the Client,

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

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

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

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

a. Assistance in interviewing potential providers,

b. Assistance in understanding complicated health and safety issues,

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

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

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

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

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

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

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

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

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

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

12. Peer Mentorship as defined at Section 8.553.

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

a. Personal care services include:

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

ii) Assistance with money management,

iii) Assistance with menu planning and grocery shopping, and

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

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

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

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

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

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

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

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

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

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

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

    d. Professional services may be reimbursed only when:

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

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

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

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

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

        i) Acupuncture,

        ii) Chiropractic care,

        iii) Fitness trainer

        iv) Equine therapy,

        v) Art therapy,

        vi) Warm water therapy,

        vii) Experimental treatments or therapies, and.

        viii) Yoga.

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

a. Respite may be provided:

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

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

iii) In the community.

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

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

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

iii) Overnight Group: the Client receives respite in a setting which is defined as a facility that offers 24-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.

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

c. The following limitations to respite services shall apply:

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

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

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

17. Remote Supports means services as defined at Section 8.488

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20. Transition Setup as defined at Section 8.553.1.

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

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

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

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

ii) Purchase or lease of a vehicle, and

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

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

22. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a Client who is at least 21 years of age

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

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

c. Prior authorized in accordance with Operating Agency procedures.

**8.500.94.C PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES**

Participant direction of HCBS-SLS waiver services is authorized pursuant to the provisions of the federally approved Home and Community-Based Supported Living Services (HCBS-SLS) Waiver, CO.0293 and Section 25.5-6-1101, et seq. C.R.S.

1. Participants may choose to direct their own services through the Consumer Directed Attendant Support Services delivery OPTION SET FORTH at Section 8.510, et seq.

2. Services that may be participant-directed UNDER THIS OPTION are as follows:

   i) Personal Care as defined at Section 8.500.94.B.12

   ii) Homemaker services as defined at Section 8.500.94.B.8

   iii) Health Maintenance Activities as defined at Section8.500.94.B.5

3. The case manager shall conduct the case management functions SET FORTH at Section 8.510.14, et seq.

**8.500.95 SERVICE PLAN:**

The Case Management Agency shall complete a service plan for each Client enrolled in the HCBS-SLS waiver in accordance with Section 8.519.11.B.2

8.500.95.D The Service Plan must be reported in the Department prescribed system and include the following employment information for individuals eligible for or receiving Supported Employment services, if applicable:

1. Sector and type of employment.

2. Mean wage per hour earned.

3. Mean hours worked per week.

**8.500.96 WAITING LIST PROTOCOL**

8.500.96.A When the federally approved waiver capacity has been met, persons determined eligible to receive services under the HCBS-SLS, shall be eligible for placement on a waiting list for services.

8.500.96.B Waiting lists for persons eligible for the HCBS-SLS waiver program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Operating Agency's procedures.

8.500.96.C Persons determined eligible shall be placed on the waiting list for services in the Community Centered Board service area of residency.

8.500.96.D Persons who indicate a serious intent to move to another service area should services become available shall be placed on the waiting list in that service area. Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in the Operating Agency's procedures for placement on a waiting list in a service area other than the area of residency.

8.500.96.E The date used to establish a person's placement on a waiting list shall be:

1. The date on which eligibility for developmental disabilities services in Colorado was originally determined; or

2. The fourteenth (14th) birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

8.500.96.F As openings become available in the HCBS-SLS waiver program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:

1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered and the emergency cannot be resolved in another way. Emergencies are defined as follows:

   a. Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode.

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

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

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

   e. The Legislature has appropriated funds specific to individuals or to a specific class of persons.

   f.. If an eligible individual is placed on a waiting list for SLS waiver services, a written notice, including information regarding the Client appeals process, shall be sent to the individual and/or his/her legal guardian in accordance with the provisions of Section 8.057, *et seq*.

**8.500.97 CLIENT RESPONSIBILITIES**

8.500.97.A A Client or the Client’s family or guardian is responsible for:

1. Providing accurate information regarding the Client’s ability to complete activities of daily living,

2. Assisting in promoting the Client’s independence,

3. [no text]

4. Cooperating in the determination of financial eligibility,

5. Notifying the case manager within thirty (30) days after:

a. Changes in the Client's support system, medical condition and living situation including any hospitalizations, emergency room admissions,

b. Placement to a nursing home or intermediate care facility for the individuals with intellectual disabilities (ICF-IID),

c. The Client has not received an HCBS waiver service during one (1) month

d. Changes in the Client's care needs,

e. Problems with receiving HCBS-SLS waiver services, and

f. Changes that may affect Medicaid financial eligibility including prompt report of changes in income or assets.

**8.500.98 PROVIDER REQUIREMENTS**

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

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

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in Section 8.130,

4. Discontinue HCBS-SLS services to a Client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

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

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

7. Maintain Client records to substantiate claims for reimbursement according to Medicaid standards.

8.500.98.B HCBS-SLS providers shall comply with:

1. All applicable provisions of Title 27, Article 10.5, C.R.S., and the rules and regulations as set forth in Section 8.600.

2. All federal program reviews and financial audits of the HCBS-SLS waiver services,

3. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,

4. Requests from the county Departments of Social/Human Services to access records of Clients receiving services held by case management agencies as required to determine and re-determine Medicaid eligibility;

5. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-SLS waiver, and

6. Requests by the case management agency to monitor service delivery through targeted case management activities.

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

   a. Subject to the availability of appropriations for reimbursement in section 8.500.104.G, Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

      i. Deadlines.

         1) Existing staff, employed by the Provider on or before July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

         2) Newly hired staff, employed by the Provider after July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

            a) 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.

      ii. Department approval required.

         1) The Training Certificate or Certification required under section 8.500.98.C.1.a must be pre-approved by the Department.

            a) Providers 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) Seeking approval for:

                  1. Training Certificate, or

2. Certification, or

3. Training Certificate and Certification.

iv) Name 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) Name 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:

1. Whether a certificate of completion is received.

vii) Date of Certification exam, if applicable.

b) Department approval will be based on alignment with the following core competencies:

i) Core values and principles of Supported Employment, including the following:

1. The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.

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 Clients 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 Clients with significant disabilities, which meets the needs of both the employer and the Client.

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 8.500.98.C.1.a.ii.1.a.

**8.500.99 TERMINATION OR DENIAL OF HCBS-SLS MEDICAID PROVIDER AGREEMENTS**

8.500.99.A The Department may deny or terminate an HCBS-SLS Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at Section 8.130 et seq,

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-SLS services,

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider,

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper Client notification,

5. Emergency termination of any provider agreement shall be in accordance with procedures at Section 8.050, and

8.500.99.B The provider fails to comply with requirements for submission of claims pursuant to Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

**8.500.100 ORGANIZED HEALTH CARE DELIVERY SYSTEM**

8.500.100.A The Organized Health Care Delivery System (OHCDS) for the HCBS-SLS waiver is the Community Centered Board as designated by the Operating Agency in accordance with Section 27-1010.5-103,.

8.500.100.B The OHCDS is the Medicaid provider of record for a Client whose services are delivered through the OHCDS,

8.500.100.C The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS according to the current federally approved waiver.

8.500.100.D The OHCDS may contract or employ for delivery of HCBS Waiver services.

8.500.100.E The OCHDS shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS Waiver,

2. Ensure that services are delivered according to the waiver definitions and as identified in the Client's service plan,

3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

4. Monitor the health and safety for HCBS Clients receiving services from a subcontractor.

8.500.100.F The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to Clients,

4. Negotiate rates that are in accordance with the Operating Agency's established fee for service rate schedule and Operating Agency procedures,

   a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

5. Collect and maintain the data used to develop provider rates and ensure data includes costs for services to address the Client's needs, that are allowable activities within the HCBS service definition and that supports the established rate,

6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency or Centers for Medicare and Medicaid Services (CMS), and

7. Report by August 31 of each year, the names, rates and total payment made to the contractor.

**8.500.101 PRIOR AUTHORIZATION REQUESTS**

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14

**8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)**

8.500.102.A The service plan authorization limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a Client's ongoing service needs within one (1) service plan year.

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations, vehicle modifications, health maintenance activities available under the Consumer Directed Attendant Support Services (CDASS), home delivered meals, life skills training, peer mentorship, and transition setup.

8.500.102.C The total of all HCBS-SLS services in one service plan shall not exceed the overall authorization limitation as set forth in the federally approved HCBS-SLS waiver.

8.500.102.D Each SPAL is assigned a specific dollar amount determined through an analysis of historical utilization of authorized waiver services, total reimbursement for services, and the spending authority for the HCBS-SLS waiver. Adjustments to the SPAL amount may be determined by the Department and Operating Agency as necessary to manage waiver costs.

8.500.102.E Each SPAL is associated with one of the six support levels determined by an algorithm which analyzes the level of support needed by a Client as determined by the SIS assessment, and additional factors, including whether a Client meets the definition of Public Safety Risk-Convicted, Public Safety Risk-Non Convicted, and Extreme Safety Risk to Self..

8.500.102.F The SPAL determination shall be implemented in a uniform manner statewide and the SPAL amount is not subject to appeal.

1. If a Client's HCBS waiver eligibility and/or services are adversely affected at any time, the Client will be sent their appeal rights as required at 8.612.4.E. and 8.057.2.A (10 C.C.R. 2505-10).

8.500.102.G The Department and/or Utilization Review Contractor (URC) shall implement an Exception Review to allow a Member's SPAL and/ or HCBS unit limitations to be exceeded in certain situations.

1. To be eligible for the Exception Review Process, the following shall be demonstrated:

    a. The Client must be at risk for seeking an emergency Developmental Disability (DD) waiver enrollment because one or more of the following criteria such as listed below are not currently being met through other Long-Term Services and Supports (LTSS) and or State Plan services:

        i. Medically fragile with skilled care needs;

        ii. Behavioral and/or Mental Health needs;

        iii. Criminal convictions and/or law enforcement involvement;

        iv. Homelessness;

        v. Mistreatment, Abuse, Neglect, Exploitation (MANE) reports with potential need to remove from home;

        vi. Extreme danger to self/others;

        vii. Caregiver capacity or;

        viii. 1:1 supervision needed.

    b. The Client must demonstrate that less than 10% of current SPAL remains; or

c. The Client must demonstrate that the current rate of utilization of Home and Community-Based Services (HCBS) will exhaust the number of approved units prior to the Client's regularly scheduled monitoring.

2. When a client is eligible for the Exception Review Process, the Case Manager (CM) shall send the following documentation to the URC for review:

a. "Request for Exception Review Process" form;

b. Service Plan;

c. PAR; and,

d. Any documentation from current providers that demonstrate need to exceed service limitation caps for additional planned services.

3. The URC shall review and approve or deny the Exception Review Process requests made.

a. Upon completion of the review, the URC shall notify the CM of the outcome.

i. The outcome letter shall include the reason for approval or denial, and/ or any information on partial approvals or negotiated outcomes.

b. The URC shall compete the review in accordance with the timelines as identified in their contract.

4. The Exception Review Process shall not be used in place of a Support Level Review or request for a Support Intensity Scale (SIS) reassessment. Provider rates shall not be changed based on the outcome of the Exception Review Process.

5. The Exception Review Process shall be implemented in a uniform manner applied to Members statewide, but outcomes shall be based on individual needs and circumstances. The Exception Review Process outcome is not an adverse action subject to appeal.

a. If a Client's HCBS waiver eligibility and/or services are adversely affected at any time, the Client will be sent their appeal rights as required at 8.612.4.E. and 8.057.2.A (10 C.C.R. 2505-10).

**8.500.103 RETROSPECTIVE REVIEW PROCESS**

8.500.103.A Services provided to a Client are subject to a retrospective review by the Department and the Operating Agency. This retrospective review shall ensure that services:

1. Identified in the service plan are based on the Client's identified needs as stated in the functional needs assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a Client are in accordance with the service plan, and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

8.500.103.B When the retrospective review identifies areas of non compliance, the case management agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.103.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.500.103.D When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status

**8.500.104 PROVIDER REIMBURSEMENT**

8.500.104.A Providers shall submit claims directly to the Department's fiscal agent through the Medicaid management information system (MMIS); or through a qualified billing agent enrolled with the Department's fiscal agent.

8.500.104.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally approved HCBS-SLS waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance with the frequency, amount, scope and duration of the service as identified in the Client's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.104.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.104.D When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.104.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claim submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.104.F Except where otherwise noted, payment is based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin accessed through the Department's fiscal agent's web site.

8.500.104.G Reimbursement for Supported Employment Training Certificate or Certification, or both, under section 8.500.98.C.1.a, 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 providers for such costs.

1. Providers seeking reimbursement for a completed Training Certificate or Certification approved under section 8.500.98.C.1.a.ii.1.c must submit the following to the Department:

    a. Supported Employment Providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

        i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving documentation under section 8.500.104.G.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under Section 8.500.98.C.1.a.ii and either notify the Provider of the denial or, if approved, reimburse the Provider.

    a. Reimbursement is limited to the following amounts, and includes wages:

        ii. Up to $300 per certification exam.

        iii. Up to $1,200 for each training.

**8.500.105 INDIVIDUAL RIGHTS**

8.500.105.A The rights of a Client in the HCBS-SLS Waiver shall be in accordance with Sections 27-10.5-112 through 131, C.R.S.

**8.500.106 APPEAL RIGHTS**

Case Management Agencies shall meet the requirements set forth at Section 8.519.22

8.500.106.A The CCB shall provide the long-term care notice of action form to applicants and Clients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq*. when:

1. The Client or applicant is determined to not have a developmental disability,

2. The Client or applicant is found eligible or ineligible for LTSS,

3. The Client or applicant is determined eligible or ineligible for placement on a waiting list for LTSS,

4. An adverse action occurs that affects the Client's or applicant's waiver enrollment status; or,

8.500.106.B The CCB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CCB has made a denial or other adverse action against a Client or applicant.

8.500.106.C The CCB shall notify the Case Management Agency in the Client's service plan within one (1) business day of the adverse action.

8.500.106.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.106.E The applicant or Client shall be informed of an adverse action if the Client is determined ineligible and the following:

1. The Client or applicant s detained or resides in a correctional facility, or

2. The Client or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

**8.500.107 QUALITY ASSURANCE**

8.500.107.A. The monitoring of services provided under the HCBS-SLS waiver and the health and well-being of Clients shall be the responsibility of the Operating Agency, under the oversight of the Department.

8.500.107.B. The Operating Agency shall conduct on-site surveys or cause to have on-site surveys to be done in accordance with guidelines established by the Department or the Operating Agency. The survey shall include a review of applicable Operating Agency rules and regulations and standards for HCBS-SLS.

8.500.107.C The Operating Agency, shall ensure that the case management agency fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.

8.500.107.D The Operating Agency, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials which pertain to the operation and service delivery of the SLS waiver program.

8.500.107.E The Operating Agency shall recommend to the Department the suspension of payment denial or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.107.F After receiving the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action.

**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.

## 8.501 State Funded Supported Living Services Program

The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide supports 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.

### 8.501.A Definitions

1. APPLICANT means an individual who is seeking supports from State-SLS program.

2. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to section 25.5-10-209.5, C.R.S., has a valid provider participation agreement with the Department, and has a valid contract with the Department to provide these services.

3. CCB CASE MANAGER means the staff member of the Community Centered Board that works with individuals seeking services to develop and authorize services under the State-SLS program.

4. CLIENT means an individual who meets the DD Determination criteria and other State-SLS eligibility requirements and has been approved for and agreed to receive services in the State-SLS program.

5. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

6. 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.

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

8. COMMUNITY RESOURCE means services and supports that a Client 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.

9. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

10. Developmental Disability (DD) Determination means the determination of a Developmental Disability as defined in section 8.607.2

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

12. DEVELOPMENTAL DISABILITY means a disability that is defined in section 8.600.4.

13. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).

14. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

15. LONG-TERM CARE SERVICES AND SUPPORTS (LTSS) means the services and supports utilized by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

16. MEDICAID ELIGIBLE means an Applicant or Client meets the criteria for Medicaid benefits based on a financial determination and disability determination.

17. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses federal Medicaid statutory requirements concerning the operation of its Medicaid program.

18. NATURAL SUPPORTS means an informal relationship that provides assistance and occurs in the Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

19. 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 CCB to ensure quality and compliance with all statutory and regulatory requirements.

20. PLAN YEAR mean a twelve (12) month period starting from the date when State-SLS Supports and Services where authorized.

21. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent.

22. PROGRAM APPROVED SERVICE AGENCY (PASA) means a developmental disabilities service agency or a service agency as defined in 8.602, that has received program approval, by the Department, to provide Medicaid Wavier services.

23. RELATIVE means a person related to the Client by virtue of blood, marriage, or adoption.

24. RETROSPECTIVE REVIEW means the Department’s review after services and supports are provided and the PASA is reimbursed for the service, to ensure the Client received services according to the service plan and standards of economy, efficiency and quality of service.

25. STATE-SLS INDIVIDUAL SUPPORT PLAN means the written document that identifies an individual's need and specifies the State-SLS services being authorized, to assist a Client to remain safely in the community.

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

27. Services and Supports or Supports and Services means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided to

    a. To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience person security and self-respect.

28. SUPPORT SERVICE means the service(s) established in the State SLS program that a CCB Case Manager may authorize to support an eligible Client to complete the identified tasks identified in the Client's Individualized Support Plan.

29. WAIVER SERVICE means optional services and supports defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

**8.501.2 Administration:**

1. The CCB shall administer the State-SLS program according to all applicable statutory, regulatory and contractual requirements, and Department policies and guidelines.

    a. The CCB is responsible for providing case management to all individuals enrolled in the State-SLS program.

    b. The CCB 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 8.130.2.

    d. The CCB shall maintain a waiting list of eligible individuals for whom Department funding is unavailable in accordance with section 8.501.7.

    e. The CCB 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 8.501.7.

    f. Any decision to modify, reduce or deny services or supports set forth in the State SLS program, without the Individual's or Guardian's agreement, are subject to the requirements in Section 8.605.

2. 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 8.607.2.

b. Eligibility for the State-SLS program does not guarantee the availability of services and supports 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 CCBs.

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 Client.

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 CCB 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 CCB Case Manager shall authorize a Program Approved Service Agency (PASA) to deliver the services, when available.

g. When a PASA is not available the CCB Case Manager may authorize and provide the Support Service, through the State-SLS program, to assist the Client with tasks identified in his or her Individual Support Plan.

h. The CCB Case Manager may authorize Services and Supports from multiple State-SLS service categories at once, unless otherwise stated.

i. Unless otherwise specified, State-SLS Services and Supports may be utilized in combination with other Community Resources and/or Medicaid Services and Supports, as long as they are not duplicative, and all other available and accessible resources are utilized first.

4. Performance and Quality Review

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

b. A CCB found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but 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 time-frame 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 CCB shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The CCB 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 CCB 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 CCB 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 CCB 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.

**8.501.3 CCB and PASA Reimbursement**

1. A PASA must submit all claims, payment requests, and/or invoices to the CCB 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 and Supports rendered in June must be submitted by the date specified by the CCB to ensure payment.

2. CCBs must submit all claims, payment requests, and/or invoices in the format and timeframe established by the Department.

3. CCB's and PASA's claims, payment requests, or invoices for reimbursement shall be made only when the following conditions are met:

a. Services and Supports are provided by a qualified PASA.

b. Services and Supports are authorized and delivered in accordance with the frequency, amount, scope and duration of the service as identified in the Client'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 CCB.

1. CCBs and PASAs shall maintain records in accordance with Section 8.130.2.

2. CCB and PASA reimbursement shall be subject to review by the Department and may be completed after the payment has been made to the CCB and PASA. CCBs and PASAs are subject to all program integrity requirements in accordance with section 8.076.

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

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

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

**8.501.4 State-SLS Covered Services and Supports**

**8.501.4.A. Supports for Individuals waiting for HCBS waiver enrollment.**

1. Eligible Clients may receive the following Services and Supports

a. All Services and Supports identified in the HCBS-SLS waiver identified in section 8.500.94

b. Service limitations in the HCBS-SLS waiver and set forth in section 8.500 apply to the State-SLS program.

c. When a PASA is not available to provide Supports and Services the CCB may authorize the Support Services, to provide the needed Supports and Services identified in the State-SLS Individual Support Plan.

**8.501.4.B Supports for Individuals Experiencing Temporary Hardships**

1. State-SLS may be utilized to provide the following temporary Supports and Services to Individuals who have been determined to meet the criteria for an Intellectual / Developmental Disability as specified in Section 8.607.2, in situations where temporary assistance can alleviate the need for a higher level of care. These Services and Supports cannot be duplicative and shall not be accessed if available through other sources. In order to access State-SLS, an Individual Support Plan must be completed.

a. Payment of utilities:

i. Paying gas/electric bills and/or water/sewer bills:

Documentation must be maintained by the CCB that all alternative programs, community support, and Natural Supports were utilized before any State-SLS funds were authorized.

b. Supports with acquiring emergency food, at a retail grocery store when there are no other community resources available

i. Documentation must be maintained by the CCB demonstrating the reason why State-SLS funds were utilized over other sources of emergency food. This may include but is not limited to:

1) Other emergency food programs are not available.

2) Home delivered meals have unexpectedly stopped.

c. Pest infestation abatement:

i. Documentation must be maintained by the Case Manager showing that infestation abatement is not covered under the Client's residential agreement or lease.

ii. Documentation that the pest abatement professional is licensed in the state of Colorado, must be maintained by the CCB and provided to the Department upon request.

iii. Pest infestation abatement shall not be authorized if the Client resides in a PASA owned and/or controlled property.

iv. Documentation showing proof of payment must be maintained by the CCB administering the State-SLS program;

2. Service Limitations

a. Support for utilities shall not exceed $1000.00 in a State Fiscal Year.

b. Support for pest infestation abatement shall not exceed $2000.00 in a State Fiscal Year;

i. Supports for pest infestation abatement shall not cover more than one infestation event in a State Fiscal Year; and

ii. 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.

**8.501.4.C Supporting Independence in the Community.**

1. State-SLS may be utilized to provide an individual found eligible for or enrolled in an HCBS Medicaid waiver, with a one-time payment or acquisition of needed household items, in the event the Client is moving into a residence as defined in Section 8.500.93.A.(7).

a. State-SLS funds may be utilized for payment or acquisition of

i. initial housing costs including but not limited to a one-time initial set up for pantry items and/or kitchen supplies and/or furniture purchase.

b. Individuals enrolled in the HCBS-DD waiver residing in an Alternative Care Facility (ACF), Group Residential Supports and Services (GRSS) or Individual Residential Supports and Services - Host Home (IRSS-HH) setting are not eligible for this Support.

2. State-SLS funds may support someone to have greater independence when they are moving into their own home, by paying for housing application fee.

3. The CCB shall maintain receipts or paid invoices for purchases authorized in this section. Receipts or paid invoices must contain at a minimum, the following information: business name, item(s) purchased, item(s) cost, date paid, and description of items purchased. Documentation must be made available to the Department upon request. All items must be purchased from an established retailer that has a valid business license.

4. Service limitations

a. The one-time furniture purchase shall not exceed $300.00.

b. The one-time initial pantry set up shall not to exceed $100.00.

c. The one-time purchase of kitchen supplies shall not to exceed $200.00.

d. The payment of housing application fees are limited to five (5) in a State Fiscal Year.

**8.501.4.D On-going State-SLS Support.**

1. State-SLS funds may be authorized by the CCB 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 8.500.93.

a. An eligible Client may be authorized to receive any service set forth in the HCBS-SLS waiver regulation at section 8.500.90.

b. Service limitation and service rules found in the HCBS-SLS waiver regulation at section 8.500.90 applies to the State SLS program.

c. A Program Approved Service Agency (PASA) is authorized to provide State-SLS services; and

2. When an individual is enrolled in an HCBS waiver, other than the HCBS-DD or HCBS-SLS waiver and needed Supports and Services not provided by that waiver, the CCB may authorize State-SLS funds.

a. A comparable service must not be available in the enrolled waiver.

b. State-SLS funds may not be utilized for Home Accessible Adaptation, or Vehicle Modification.

c. Only a PASA shall provide these services.

3. Service Limitation

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

**8.501.4.E State-SLS Individual Support Plan.**

1. State-SLS Clients are required to have a State SLS Individual Support Plan that is signed and authorized by the CCB Case Manager and the Client, or their Guardian.

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 CCB Case Manager. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.

3. If a Client seeks additional supports or alleges a change in need, the State-SLS Individual Support Plan shall be reviewed and updated by the CCB Case Manager prior to any change in authorized services and supports.

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 Client 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 Client (e.g. natural disaster, pandemic, etc.

   a. Any changes to the provision of the services and supports identified in the State-SLS Individual Support Plan are subject to available funds within the designated service area.

   b. Any decision to modify, reduce or deny services and supports set forth in the State-SLS Individual Support Plan, without the Client's consent is subject to the Dispute Resolution Process found in section 8.605.2.

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 Supports and Services authorized, the Client's identified needs and how the Supports and Service will address the needs.

   b. The scope, frequency, and duration of each service.

   c. 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.

   d. Total cost of the supports being authorized.

e. Information to support authorization of services under Supports 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 Client gaining more independence in the community or maintaining their independence in the community.

f. Additional Information required for authorization of services for the purpose of Supporting Independence in the Community:

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

g. Additional Information to be included for authorization of services On-going State -SLS Supports;

i. Documentation demonstrating why the individual enrolled in State-SLS is not eligible or enrolled in a HCBS Medicaid waiver or documentation showing which HCBS waiver the individual is enrolled in; and

ii. Documentation demonstrating how authorized services are not duplicative or comparable to others the individual is eligible for or has access to.

**8.501.5 Case Management Services**

**8.502.5.A Administration**

1. CMAs shall comply with all requirements set forth in section 8.607.1.

**8.501.5.B Case Management Duties:**

1. The case manager shall coordinate, authorize and monitor services based on the approved State-SLS Individual Support Plan.

a. The case manager shall have, based on the Client's preference, a face to face or telephone contact once per quarter with the Client.

2. The CCB Case Manager shall assist Clients to gain access to other resources for which they are eligible and to ensure Clients secure long-term support as efficiently as possible.

3. The CCB Case Manager shall provide all State-SLS documentation upon the request from the Department.

4. Referrals to the State-SLS program shall be made through the CCB in the geographic catchment area the Client or Applicant resides in.

**8.501.6 Transferring Services Between Community Centered Boards:**

1. When an individual enrolled in, or on the waiting list for, the State-SLS program moves to another CCB's catchment area, and wishes to transfer their State-SLS, the following procedure shall be followed:

    a. The originating CCB will contact the receiving CCB to inform them of the individual's desire to transfer.

    b. The originating CCB will send the State-SLS Individual Support Plan to the receiving CCB, where the receiving CCB will determine if appropriate State-SLS funding is available or if the individual will need to be placed on a waiting list. The receiving CCB's decision of service availability will be communicated in the following way:

        i. The receiving CCB 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 CCB will notify the originating CCB 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 CCB shall contact the individual requesting the transfer no more than 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 in fifteen (15) business days of when the notification of service determination is sent out by the receiving CCB. 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 CCB must ensure that:

i. the transferring individual meets his or her primary contact of the receiving CCB.

ii. The individual is informed of the date when Services and Supports will be transferred, when Services and Supports will be available, and the length of time the Supports and Services will be available.

g. The receiving CCB case manager shall have an in-person face to face meeting with the Client to review and update the State-SLS Individual Support Plan, prior to the Supports and Services being authorized. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

**8.501.7 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 Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Operating Agency's procedures.

3. Persons determined eligible shall be placed on the waiting list for services in the Community Centered Board 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 designated service area, persons shall be considered for services in order of placement on the local Community Centered Board'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 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; or whose primary residence during the night is a public or private facility that provides temporary living accommodations; or any other unstable or non-permanent situation; or 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 him/her. 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 s/he is seriously injuring/harming himself/herself or is in 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; or the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or 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 CCB and made available to the Department upon request.

## 8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (HCBS-CES)

## 8.503 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, transferring, and needing supervision to support behavior, medical needs and memory cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-CES waiver or a HCBS waiver service.

C. APPLICANT means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service 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) as defined at Section 8.510.1.

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

F. CLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-based Services (HCBS).

G. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

I. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-based Services, and Medicaid State Plan benefits including long-term home health services and targeted case management.

J. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

K. CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single state Medicaid agency.

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and is defined as:

A mother, father, brother, sister,

Extended blood relatives such as grandparent, aunt, uncle, cousin,

An adoptive parent,

One or more individuals to whom legal custody of a person with a developmental disability has been given by a court,

A spouse or,

The Client's child.

Q. FISCAL MANAGEMENT SERVICE (FMS) means the entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual Client allocations for CDASS.

R. FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for long-term services and supports as determined by the Department

S. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long-term Care instrument and medical verification on the Professional Medical Information Page to determine if the applicant or Client meets the institutional Level off Care (LOC).

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

U. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

V. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

W. INSTITUTION means a hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the state plan.

X. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately operated facility that provides health and habilitation services to a Client with developmental disabilities or related conditions.

Y. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse

Z. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

AA. LICENSED MEDICAL PROFESSIONAL means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses: physician, physician assistant and nurse governed by the Colorado Medical License Act and the Colorado Nurse Practice Act.

BB. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

CC. MEDICAID ELIGIBLE means the applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

DD. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

EE. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

FF. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

GG. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in Home and Community Services for persons with Developmental Disabilities (HCBS-DD), HCBS- Supported Living Services (HCBS-SLS) and HCBS- Children's Extensive Supports (HBCS-CES) waivers.

HH. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to certify the Applicant's or Client's need for long-term care.

JJ. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received program approval to provide HCBS-CES waiver services.

KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the Client received services according to the service plan and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

MM. SERVICE PLAN means the written document that specifies identified and needed services, regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules

NN. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

OO. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

PP. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

QQ. UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the Department to review the HCBS-CES waiver applications for determination of eligibility based on the additional targeting criteria.

RR. WAIVER SERVICE means optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

**8.503.10 HCBS-CES WAIVER ADMINISTRATION**

A. This section hereby incorporates the terms and provisions of the federally approved Home and Community-based Services-Children's Extensive Support (HCBS-CES) waiver CO.4180.R03.00. To the extent that the terms of that federally approved waiver are inconsistent with the provisions of this section, the waiver will control

B. HCBS-CES waiver for Clients ages birth through seventeen years of age with Developmental Delays or disabilities is administered through the designated Operating Agency.

C. HCBS-CES waiver services shall be provided in accordance with the federally approved HCBS-CES waiver document and these rules and regulations.

D. HCBS-CES waiver services are available only to address needs identified in the Functional Needs Assessment and authorized in the Service Plan and when the service or Support is not available through the Medicaid State Plan, EPSDT, Natural Supports, or third party payment sources.

E. HCBS-CES waiver:

1. Shall not constitute an entitlement to services from either the Department or its agents;

2. Shall be subject to annual appropriations by the Colorado General Assembly;

3. Shall limit the utilization of the HCBS-CES waiver based on the federally approved capacity, Cost Containment, the maximum costs and the total appropriations; and,

4. May limit enrollment when utilization of the HCBS-CES waiver program is projected to exceed the spending authority.

**8.503.20 GENERAL PROVISIONS**

A. The following provisions apply to the HCBS – CES waiver:

1. HCBS-CES waiver services are provided as an alternative to ICF-IID services for an eligible Client to assist the Family to Support the Client in the home and community.

2. HCBS-CES waiver is waived from the requirements of Section 1902(a) (10) (b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the state of Colorado.

3. A Client enrolled in the HCBS-CES waiver shall be eligible for all other Medicaid services for which the Client qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-CES waiver. Services received through the HCBS-CES waiver may not duplicate services available through the Medicaid State Plan.

**8.503.30 CLIENT ELIGIBILITY**

A. To be eligible for the HCBS-CES waiver, an individual shall meet the target population criteria as follows:

1. Is unmarried and less than eighteen years of age,

2. Be determined to have a Developmental Disability which includes Developmental Delay if under five (5) years of age,

3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and Cost Containment limits of the HCBS-CES waiver,

4. Meet ICF-IID Level Of Care as determined by the Functional Needs Assessment,

5. Meet the Medicaid financial determination for Long-term Care (LTC) eligibility as specified at Section 8.100 *et seq.* and,

6. Reside in an eligible HCBS-CES waiver setting as defined as the following:

    a. With biological, adoptive parent(s), or legal Guardian,

    b. In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement:

        i. The case manager will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or Supports requested during the time the Client is not residing in the Family home. The case manager will submit the transition plan to the Department for approval prior to the start of services.

7. Be determined to meet the Federal Social Security Administration's definition of disability,

8. Be determined by the Department or its agent to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:

    a. The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically Age Appropriate and due to one or more of the following conditions:

        i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life-threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six (6) months,

        ii. A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six (6) months, or

        iii. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

    b. In the instance of an annual reassessment, the reassessment must demonstrate in the absence of the existing interventions or preventions provided through Medicaid that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criterion listed above.

B. The Client shall maintain eligibility by meeting the HCBS-CES waiver eligibility as set forth in Section 8.503 and the following:

1. Receives at least one (1) HCBS-CES waiver service each calendar month,

2. Is not simultaneously enrolled in any other HCBS waiver, and

3. Is not residing in a hospital, nursing facility, ICF-IID, other Institution or correctional facility.

**8.503.40 HCBS-CES WAIVER SERVICES**

A. The following services are available through the HCBS-CES waiver within the specific limitations as set forth in the federally approved HCBS-CES waiver:

1. Adaptive therapeutic recreational equipment and fees are services which assist a Client to recreate within the Client's community. These services include recreational equipment that is adapted specific to the Client's disability and not those items that a typical age peer would commonly need as a recreation item.

a. The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.

b. Adaptive therapeutic recreational equipment may include 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 Client with a Developmental Disability.

c. A pass for admission to recreation centers for the Client 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 as day passes or monthly passes, whichever is the most cost effective.

d. Adaptive therapeutic recreation fees include those for water safety training.

e. The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. Entrance fees for zoos,

ii. Museums,

iii. Butterfly pavilion,

iv. Movie, theater, concerts,

v. Professional and minor league sporting events,

vi. Outdoors play structures,

vii. Batteries for recreational items; and,

viii. Passes for Family admission to recreation centers.

f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per Service Plan year.

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

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

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

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

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

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

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

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

h. When the expected cost is to exceed two thousand five hundred (2,500) dollars per device three estimates shall be obtained and maintained in the case record.

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

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

    i. Purchase, training or maintenance of service animals,

    ii. Computers,

    iii. In home installed video monitoring equipment,

    iv. Medication reminders,

    v. Hearing aids,

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

    vii. Training, or adaptation directly related to a school or home educational goal or curriculum; or

    viii. Items considered as typical toys for children.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the Client or that enable the Client to function with greater independence in the home or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Department's procedures and the Department shall respond to exception requests within thirty (30) days of receipt.

3. Community connector services are intended to provide assistance to the Client to enable the Client to integrate into the Client's residential community and access naturally occurring resources. Community connector services shall:

a. Support the abilities and skills necessary to enable the Client to access typical activities and functions of community life such as those chosen by the general population.

b. Utilize the community as a learning environment to assist the Client to build relationships and Natural Supports in the Client's residential community.

c. Be provided to a single Client in a variety of settings in which Clients interact with individuals without disabilities, and

d. 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 under the HCBS-CES waiver and shall not be reimbursed.

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

a. Hippotherapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Hippotherapy can be reimbursed only when:

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

ii. The intervention is related to an identified medical or behavioral need; and

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

b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

i. Equine therapy,

ii. Therapeutic riding; and,

iii. Experimental treatments or therapies.

8.503.40.A.5. HOME ACCESSIBILITY ADAPTATIONS

8.503.40.A.5.a DEFINITIONS

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

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

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

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

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

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

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

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

Home Accessibility Adaptation Provider means a provider agency that meets all the standards for Home Accessibility Adaptation described in Section 8.503.A.5.e and is an enrolled Medicaid provider.

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

**8.503.40.A.5.b INCLUSIONS**

8.503.40.A.5.b.i. Home Accessibility Adaptations may include, but are not limited to, the following:

a) Installing or building ramps;

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

c) Widening or modification of doorways;

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

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

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

g) Installing stair lifts or vertical platform lifts;

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

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

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

8. 503.40.A.5.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of Section 8.503.40.A.5.

8. 503.40.A.5.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.

8. 503.40.A.5.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.

8. 503.40.A.5.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.

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

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

ii) Either:

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

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

b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule section 8.503.A.5.

**8.** 503.40.A.5.**c EXCEPTIONS AND RESTRICTIONS**

8. 503.40.A.5.c.i Home Accessibility Adaptations must be a direct benefit to the Participant and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.

8. 503.40.A.5.c.ii Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, are prohibited.

8. 503.40.A.5.c.iii Adaptations, improvements, or modifications as a part of new construction costs are prohibited.

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

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

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

ii) configure a bathroom to accommodate a wheelchair.

c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department procedures.

8. 503.40.A.5.c.iv The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.

8.503.40.A.5.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.

8.503.40.A.5.c.vi. Upgrades beyond what is the most cost-effective means of meeting the Participant's identified need, including, but not limited to, items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

8.503.40.A.5.c.vii. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

a) Roof repair,

b) Central air conditioning,

c) Air duct cleaning,

d) Whole house humidifiers,

e) Whole house air purifiers,

f) Installation 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.

8.503.40.A.5.c.viii. Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.

8.503.40.A.5.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.503.40.A.5.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the 2018 Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to Sect24-4-103(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. 503.40.A.5.d CASE MANAGEMENT AGENCY RESPONSIBILITIES**

8. 503.40.A.5.d.i. The Case Manager shall consider alternative funding sources to complete the Home Accessibility Adaptation. These alternatives considered and the reason they are not available shall be documented in the case record.

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

8. 503.40.A.5.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval and confirmation of Home Accessibility Adaptation fund availability.

8. 503.40.A.5.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization Request form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5. Home Accessibility Adaptations submitted with improper documentation will not be approved.

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

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

8. 503.40.A.5.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

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

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

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

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

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

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

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

8. 503.40.A.5.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:

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

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

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

a) Description of the work to be completed.

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

c) Estimate for building permits, if needed,

d) Estimated timeline for completing the project,

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

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

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

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

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

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

5) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.503.40.A.5 and the recommendations of the OT/PT evaluation.

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

6) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.503.40.A.5.

8. 503.40.A.5.d.vi. If a property to be modified is not owned by the Participant or their guardian, the Case Manager shall obtain physical or digital, signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein.

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

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

8. 503.40.A.5.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation, the Department may hold the CMA financially liable for the increased cost.

8. 503.40.A.5.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR.

**8. 503.40.A.5.e PROVIDER RESPONSIBILITIES**

8. 503.40.A.5.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in Section 8.500.98.

8. 503.40.A.5.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the Home Accessibility Adaptation services will be performed, if required by that city or county.

8. 503.40.A.5.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

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

2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

8. 503.40.A.5.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's expense.

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

8. 503.40.A.5.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8. 503.40.A.5.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Accessibility Adaptation projects may be inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. Participants must provide access for inspections.

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

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

3) Home Accessibility Adaptation providers must repair or correct any noted deficiencies within twenty (20) days or the time required by the inspection, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

8. 503.40.A.5.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis for non-payment or recovery of payment by the Department.

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

a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5.

b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5.

**8. 503.40.A.5.f REIMBURSEMENT**

8. 503.40.A.5.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments.

8. 503.40.A.5.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8. 503.40.A.5.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation to DOH:

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

2) Required permits;

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

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

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

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

c) Approval by the home owner or property manager;

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

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

8. 503.40.A.5.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8. 503.40.A.5.f.v. The Home Accessibility Adaptation Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.

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

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

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

8. 503.40.A.5.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.

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

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

8. 503.40.A.5.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

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

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

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

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

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

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

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

1). When such Support is incidental to the habilitative services being provided,

2). To increase independence of the Client,

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

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

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

a. Massage therapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Massage therapy is reimbursed only when:

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

ii. The intervention is related to an identified medical or behavioral need; and

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

b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

i. Acupuncture,

ii. Chiropractic care, and,

iii. Experimental treatments or therapies.

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

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

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

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

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

   b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

      i. Fitness training (personal trainer),

      ii. Warm water therapy,

      iii. Experimental treatments or therapies, and

      iv. Yoga.

9. Parent education provides unique opportunities for parents or other care givers to learn how to Support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. Parent education includes:

   a. Consultation and direct service costs for training parents and other caregivers in techniques to assist in caring for the Client's needs, including sign language training,

   b. Special resource materials,

   c. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the Client's disability, and

   d. Cost of membership to parent Support or information organizations and publications designed for parents of children with disabilities.

   e. The maximum service limit for parent education is one thousand (1,000) units per Service Plan year.

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

i. Transportation,

ii. Lodging,

iii. Food, and

iv. Membership to any political organizations or any organization involved in lobby activities.

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

a. Respite may be provided:

i. In the Client's home or a private residence,

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

iii. In the community.

b. Respite is to be provided in an Age Appropriate manner.

i. A Client eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children.

c. When the cost of care during the time the parents works is more for an eligible Client, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care.

d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible Client when supervision is needed so the primary caretaker can take the Client to receive a state plan benefit or a HCBS-CES waiver service.

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

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

ii. Individual day: the Client receives respite in a one-on-one situation for cumulatively more than 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.

iii. Overnight group: the Client 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.

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

1) Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling.

f. Federal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to Section 8.602 by the state that is not a private residence.

g. The total amount of respite provided in one Service Plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The Department may approve a higher amount based on a need due to the Client's age, disability or unique Family circumstances.

h. 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.

i. 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.

j. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a Client. Therefore, additional respite units beyond the service limit will not be approved for Clients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.

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

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

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

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

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

i. Items that are not of direct medical or remedial benefit to the Client, 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.

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

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

    b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include:

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

        ii. Purchase or lease of a vehicle, and

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

    c. The total cost of Home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the Client, to enable the Client to function with greater independence in the home, or to decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure Cost Effectiveness, prudent purchases and no unnecessary duplication.

13. Youth Day

    a. Youth day service is the care and supervision of Clients ages 12 through 17 while the primary caregiver works, volunteers, or seeks employment.

    b. Youth day service may be provided in the residence of the Client, youth day service provider, or in the community.

    c. Youth day service shall be provided according to an individual or group rate as defined below:

        i. Individual: The Client receives youth day services with a staff ratio of 1:1, billed at a 15-minute unit. There are no other youth in the setting also receiving youth day service, respite or third-party supervision.

        ii. Group: The Client receives supervision in a group setting with other individuals who may or may not have a disability. Reimbursement is limited to the Client.

    d. Limitations:

        i. This service is limited to Clients ages 12 through 17.

ii. This service may not substitute for or supplant special education and related services included in a Client's Individualized Education Plan (IEP) developed under Part B of the Individuals with Disabilities Education Act, 20 U.S.cC. § 1400 (2011). This includes after school care provided through any education system and funded through any education system for any student.

iii. This service may not be used to cover any portion of the cost of camp.

iv. This service is limited to ten (10) hours per calendar day.

**8.503.50 SERVICE PLAN.**

The case management agency shall complete a service plan for each Client enrolled in the HCBS-CES waiver in accordance with Section 8.519.11.B.2.

**8.503.60 WAITING LIST PROTOCOL**

A. When the HCBS-CES waiver reaches capacity for enrollment, a Client determined eligible for HCBS-CES waiver benefits shall be placed on a statewide waiting list in accordance with these rules and the Department's procedures.

1. The Community Centered Board shall determine if an Applicant has Developmental Delay if under age five (5), or Developmental Disability if over age five (5) , prior to submitting the HCBS-CES waiver application to the Department or its agent. Only a Client who is determined to have a Developmental Delay or Developmental Disability may apply for HCBS-CES waiver.

2. In the event a Client who has been determined to have a Developmental Delay is placed on the wait list prior to age five (5), and that Client turns five (5) while on the HCBS-CES waiver wait list, a determination of Developmental Disability must be completed in order for the Client to remain on the wait list.

3. The Case Management Agency shall complete the Functional Needs Assessment, as defined in Department rules, to determine the Client's Level of Care.

4. The Case Management Agency shall complete the HCBS-CES waiver application with the participation of the Family. The completed application and a copy of the Functional Needs Assessment that determines the Client meets the ICF-IID Level Of Care shall be submitted to the Department or its agent within fourteen (14) calendar days of parent signature.

5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the Department or its agent.

6. The Department or its agent shall review the HCBS-CES waiver application. In the event the Department or its agent needs additional information; the Case Management Agency shall respond within two (2) business days of request.

7. Any Client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide waiting list in the order in which the Department or its agent received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the Client's appeal rights in accordance with Section 8.057.

8. The Case Management Agency will create or update the consumer record to reflect the Client is waiting for the HCBS-CES waiver with the waiting list date as determined by the Department or its agent.

**8.503.70 ENROLLMENT**

A. When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.

1. The Case Management Agency shall complete the HCBS-CES waiver application and the Functional Needs Assessment in the Family home with the participation of the Family. The completed application and a copy of the Functional Needs Assessment shall be submitted to the Department or its agent within thirty (30) days of the authorized initial enrollment date.

a. If it has been less than six (6) months since the review to determine waiting list eligibility by the URC and there has been no change in the Client's condition, the Case Management Agency shall complete the Functional Needs Assessment and the parent may submit a letter to the Case Management Agency in lieu of the HCBS-CES waiver application stating there has been no change.

b. If there has been any change in the Client's condition the Case Management Agency shall complete a Functional Needs Assessment and the HCBS-CES waiver application which shall be submitted to the Department or its agent.

2. Services and Supports shall be implemented pursuant to the Service Plan within 90 days of the parent or Guardian signature.

3. All continued stay review enrollments shall be completed and submitted to the Department or its agent at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

**8.503.80 CLIENT RESPONSIBILITIES**

A. The parent or legal Guardian of a Client is responsible to assist in the enrollment of the Client and cooperate in the provision of services. Failure to do so shall result in the Client's termination from the HCBS-CES waiver. The parent or legal Guardian shall:

1. Provide accurate information regarding the Client's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions;

2. Cooperate with providers and Case Management Agency requirements for the HCBS-CES waiver enrollment process, continued stay review process and provision of services;

3. Cooperate with the local Department of Human Services in the determination of financial eligibility;

4. Complete the HCBS-CES waiver application with fifteen (15) calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a continued stay review, at least thirty (30) days prior to the end of the current certification period;

5. Complete the Service Plan within thirty (30) calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the Department or its agent.

6. Notify the case manager within thirty (30) days after changes:

   a. In the Client's Support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF-IID placements;

   b. That may affect Medicaid financial eligibility such as prompt report of changes in income or resources;

   c. When the Client has not received an HCBS-CES waiver service for one calendar month;

   d. In the Client's care needs; and,

   e. In the receipt of any HCBS-CES waiver services.

**8.503.90 PROVIDER REQUIREMENTS**

A. A private for profit or not for profit agency or government agency shall ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver and shall:

1. Conform to all state established standards for the specific services they provide under HCBS-CES waiver,

2. Maintain program approval and certification from the Department,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in Section 8.130,

4. Discontinue HCBS-CES waiver services to a Client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide HCBS-CES waiver services,

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

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

7. Maintain Client records to substantiate claims for reimbursement according to Medicaid standards.

B. HCBS-CES waiver service providers shall comply with:

1. All applicable provisions of Article 10 of Title 25.5, C.R.S. and all rules and regulations as set forth in Section 8.600,

2. All federal and state program reviews or financial audit of HCBS-CES waiver services,

3. The Department's on-site certification reviews for the purpose of program approval, on-going program monitoring or financial and program audits,

4. Requests from the County Departments of Human Services to access records of Clients and to provide necessary Client information to determine and re-determine Medicaid financial eligibility,

5. Requests by the Department to collect, review and maintain individual or agency information on the HCBS-CES waiver, and

6. Requests by the Case Management Agency to monitor service delivery through targeted case management activities.

**8.503.100 TERMINATION OR DENIAL OF HCBS-CES MEDICAID PROVIDER AGREEMENTS**

A. The Department may deny or terminate an HCBS-CES waiver Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at Section 8.076.

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-CES waiver services.

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior Client notification.

5. The provider fails to comply with requirements for submission of claims under Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with procedures at Section8.076.

**8.503.110 ORGANIZED HEALTH CARE DELIVERY SYSTEM**

A. The Organized Health Care Delivery System (OHCDS) for HCBS-CES waiver is the Community Centered Board as designated by the Department in accordance with Section 25.5 -10-209, C.R.S..

1. The OHCDS is the Medicaid provider of record for a Client whose services are delivered through the OHCDS.

2. The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS-CES waiver services according to the current federally approved waiver.

3. The OHCDS may contract or employ for delivery of HCBS-CES waiver services.

4. The OCHDS shall:

a. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver,

b. Ensure that services are delivered according to the HCBS-CES waiver definitions and as identified in the Client's Service Plan,

c. Ensure the contractor maintains sufficient documentation to Support the claims submitted, and

d. Monitor the health and safety of HCBS-CES waiver Clients receiving services from a subcontractor.

5. The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

a. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

b. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

c. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to Clients

d. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and the Department's procedures:

i. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

e. Collect and maintain the data used to develop provider rates and ensure data includes costs for the services to address the Client's needs, that are allowable activities within the HCBS-CES waiver service definition and that Supports the established rate, and

f. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency and Centers for Medicare and Medicaid Services (CMS).

g. Report by August 31 of each year, the names, rates and total payment made to the contractor.

**8.503.120 PRIOR AUTHORIZATION REQUESTS**

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14.

**8.503.130 RETROSPECTIVE REVIEW PROCESS**

A. Services provided to a Client are subject to a Retrospective Review by the Department or its agent. This Retrospective Review shall ensure that services:

1. Identified in the Service Plan is based on the Client's identified needs as stated in the Functional Needs Assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a Client are in accordance with the Service Plan, and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-CES waiver.

B. The Case Management Agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department or its agent when areas of non-compliance are identified in the Retrospective Review.

C. The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

D. When the provider has received reimbursement for services and the review by the Department or its agent identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of the provider agreement.

**8.503.140 PROVIDER REIMBURSEMENT**

A. Providers shall submit claims directly to the Department's fiscal agent through the Medicaid Management Information System (MMIS) or through a qualified billing agent enrolled with the Department's fiscal agent.

1. Provider claims for reimbursement shall be made only when the following conditions are met:

a. Services are provided by a qualified provider as specified in the federally approved HCBS-CES waiver,

b. Services have been prior authorized,

c. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the Client's Service Plan, and

d. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the Service Plan and in accordance with the service definition.

2. Provider 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 provider.

3. When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department or its agent.

4. When the provider 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 be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

**8.503.150 CLIENT RIGHTS**

A. Client rights should be in accordance with Sections 25.5-10-218 through 231, C.R.S.

**8.503.160 APPEAL RIGHTS**

Case Management Agencies shall meet the requirements set forth at Section 8.519.22

8.503.160.A The CCB shall provide the long-term care notice of action form to the applicant and Client's parent or legal guardian within eleven (11) business days regarding the Client's appeal rights in accordance with Section 8.057 *et seq.* when:

1. The Client or applicant is determined not to have a developmental delay or developmental disability,

2. The Client or applicant is determined eligible or ineligible for Medicaid LTSS,

3. The Client or applicant is determined eligible or ineligible for placement on a waiting list for Medicaid LTSS,

4. An Adverse Action occurs that affects the Client's or applicant's HCBS-CES waiver enrollment status through termination or suspension,

8.503.160.B The CCB shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the CCB has made a denial or adverse action against a Client or applicant.

8.503.160.C The CCB shall notify the Case Management Agency in the Client's service plan within one (1) business day of the adverse action.

8.503.160.D The CCB shall notify the County Department of Human Services income maintenance technician within one (1) business day of an Adverse Action that affects Medicaid financial eligibility.

8.503.160.E The CCB shall inform the applicant's or Client's parent or legal guardian of an adverse action if the applicant or Client is determined ineligible and the following:

1. The Client or applicant, parent or legal guardian fails to submit the Medicaid financial application for LTC to the financial eligibility site within thirty (30) days of LTC referral,

2. A Client, parent or legal guardian fails to submit financial information for re-determination for LTC to the financial eligibility site within the required re-determination timeframe,

3. The County Income Maintenance Technician has determined the Client no longer meets financial eligibility criteria as set forth in Section 8.100,

4. The Client cannot be served safely within the cost containment as identified in the HCBS-CES waiver,

5. The Client requires twenty-four (24) hour supports provided through Medicaid state plan,

6. The resulting total cost of services provided to the Client, including Targeted Case Management, home health and HCBS-CES waiver services, exceeds the cost containment as identified in the HCBS-CES waiver,

7. The Client enters an institution for treatment with duration that continues for more than thirty (30) days,

8. The Client is detained or resides in a correctional facility, and

9. The Client enters an institute for mental illness with a duration that continues for more than thirty (30) days.

**8.503.170 QUALITY ASSURANCE**

A. The monitoring of HCBS-CES waiver services and the health and well-being of service recipients shall be the responsibility of the Department or its agent.

1. The Department or its agent may conduct reviews of each agency providing HCBS-CES waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department. The review will apply rules and standards developed for programs serving Clients with developmental disabilities.

2. The provider agency shall maintain or cause to be maintained for six (6) years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-CES waiver or the delivery of services under the HCBS-CES waiver. The Department shall have access to these records at any reasonable time.

3. The Department may deny or terminate the Medicaid provider agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Department within the prescribed period of time.

## 8.504 HOME AND COMMUNITY BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESS WAIVER

### 8.504.05 Legal Basis

The Home and Community-based Services for Children with Life Limiting Illness program (HCBS-CLLI) in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CLLI program is also authorized under state law at Section 25.5-5-305 C.R.S.

### 8.504.1 DEFINITIONS

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

B. Bereavement Counseling means counseling provided to the Client and/or family members in order to guide and help them cope with the Client's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the Client and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.

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

D. Continued Stay Review (CSR) means a reassessment by the Single Entry Point case manager to determine the Client's continued eligibility and functional level of care.

E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital.

F. Curative Treatment means medical care or active treatment of a medical condition seeking to affect a cure.

G. Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the Client to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

H. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

I. Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood at age 19.

J. Massage Therapy means the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.

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

1. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the Client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the Client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a seamless system of care. Care Coordination does not include utilization management, that is review and authorization of service requests, level of care determinations, and waiver enrollment, provided by the case manager at the Single Entry Point.

2. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the Client'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. 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.

L. Prior Authorization Request (PAR) means the Department's prescribed form to authorize services.

M. Professional Medical Information Page (PMIP) Client means the medical information form signed by a licensed medical professional used to verify the Client needs institutional Level of Care

N. Respite Care means services provided to an eligible Client who is unable to care for himself/herself on a short-term basis because of the absence or the need for relief of those persons normally providing care. Respite Care may be provided through different levels of care depending upon the needs of the Client. Respite care may be provided in the Client's residence, in the community, or in an approved respite center location.

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

P. Therapeutic Life Limiting Illness Support means grief/loss or anticipatory grief counseling that assist the Client and family to decrease emotional suffering due to the Client's health status, to decrease feelings of isolation or to cope with the Client's life limiting diagnosis. Support is intended to help the child and family in the disease process. Support is provided to the Client to decrease emotional suffering due to health status and develop coping skills. Support is provided to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the Client, and impending death of a child. Support is provided to the Client and/or family members in order to guide and help them cope with the Client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Support will include 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.

Q. Utilization Review means approving or denying admission or continued stay in the waiver based on level of care needs, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures or settings.

**8.504.2 BENEFITS**

8.504.2.A. Home and Community-based Services under the Children with Life Limiting Illness Waiver (HCBS-CLLI) benefits shall be provided within Cost Containment.

8.504.2.B. Therapeutic Life Limiting Illness Support may be provided in individual or group setting.

1. 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.

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

8.504.2.C. Bereavement Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

1. Bereavement Counseling is limited to the Client's assessed need and is only billable one time.

2. Bereavement Counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

8.504.2.D. Expressive Therapy may be provided in an individual or group setting.

1. Expressive Therapy is limited to the Client's assessed need up to a maximum of 39 hours per annual certification period.

8.504.2.E. Massage Therapy shall be provided in an individual setting.

1. Massage Therapy shall only be used for the treatment of conditions or symptoms related to the Client's illness.

2. Massage Therapy shall be limited to the Client's assessed need up to a maximum of 24 hours per annual certification period.

8.504.2.F. Respite Care shall be provided in the home, in the community, or in an approved respite center location of an eligible Client on a short term basis, not to exceed 30 days per annual certification as determined by the Department approved Assessment. Respite Care shall not be provided at the same time as state plan Home Health or Palliative/Supportive Care services.

1. Respite Care services include any of the following in any combination necessary according to the Support Planning services:

a. Skilled nursing services;

b. Home health aide services; or

c. Personal care services

8.504.2.G. Palliative/Supportive Care shall not require a nine month terminal prognosis for the Client and includes:

1. Pain and Symptom Management; and

2. Care Coordination

8.504.2.H. HCBS-CLLI Clients are eligible for all other Medicaid state plan benefits, including Hospice and Home Health.

**8.504.3 NON-BENEFIT**

8.504.3.A. Case Management is not a benefit of the HCBS-CLLI waiver. The Single Entry Point (SEP) provides case management services as an administrative activity.

**8.504.4 CLIENT ELIGIBILITY**

8.504.4.A. An eligible Client shall:

1. Be financially eligible.

2. Be at risk of institutionalization into a hospital as determined by the SEP case manager using the Department approved assessment tool.

3. Meet the target population criteria as follows:

a. Have a life-limiting diagnosis, as certified by a physician on the Department prescribed form, and

b. Have not yet reached 19 years of age.

8.504.4.B A Client shall receive at least one HCBS-CLLI waiver benefit per month to maintain enrollment in the waiver.

1. A Client who has not received at least one HCBS-CLLI waiver benefit during a month shall be discontinued from the waiver.

2. Case Management does not satisfy the requirement to receive at least one benefit per month on the HCBS-CLLI waiver.

**8.504.5 WAIT LIST**

8.504.5.A. The number of Clients who may be served through the waiver at any one time during a year shall be limited by the federally approved HCBS-CLLI waiver document.

8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-CLLI waiver, who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a wait list maintained by the Department.

8.504.5.C. The SEP case manager shall ensure the applicant meets all criteria as set forth in Section 8.504.4.A prior to notifying the Department to place the applicant on the wait list.

8.504.5.D. The SEP case manager shall enter the Client's Assessment and Professional Medical Information Page data in the Benefits Utilization System (BUS) and notify the Department by sending the Client's enrollment information, utilizing the Department's approved form, to the program administrator.

8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish the order of an applicant's place on the wait list.

8.504.5.F. Within five working days of notification from the Department that an opening for the HCBS-CLLI waiver is available, the SEP case manager shall:

1. Reassess the applicant for functional level of care using the Department approved assessment tool if the date of the last Assessment is more than six months old.

2. Update the existing Department approved assessment tool data if the date is less than six months old.

3. Reassess for the target population criteria.

4. Notify the Department of the applicant's eligibility status.

**8.504.6 PROVIDER ELIGIBILITY**

8.504.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CLLI waiver, enter into an agreement with the Department. Providers must comply with the requirements of Section 8.130.

8.504.6.B. Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure regulations.

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

8.504.6.D. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall be one of the following:

1. Licensed Clinical Social Worker (LCSW)

2. Licensed Professional Counselor (LPC)

3. Licensed Social Worker (LSW)

4. Licensed Independent Social Worker (LISW)

5. Licensed Psychologist; or

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

8.504.6.E. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

1. 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 Clients.

2. 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 Clients.

8.504.6.F. Massage Therapy providers shall have an approved registration and be in good standing with the Colorado Office of Massage Therapy Registration.

8.504.6.G. 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.

8.504.6.H. Individuals providing Respite services shall be employed by a qualified Medicaid home health, hospice or personal care agency.

**8.504.7 PROVIDER RESPONSIBILITIES**

8.504.7.A. HCBS-CLLI providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining and terminating employees.

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to Section 19-3-307 C.R.S.

8.504.7.B. HCBS-CLLI providers shall:

1. Ensure a Client is not discontinued or refused services unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure Client records and documentation of services are made available at the request of the case manager.

3. Ensure that adequate records are maintained.

a. Client records shall contain:

i. Name, address, phone number and other identifying information for the Client and the Client's parent(s) and/or legal guardian(s).

ii. Name, address and phone number of the SEP and the Case Manager.

iii. Name, address and phone number of the Client's primary physician.

iv. Special health needs or conditions of the Client.

v. Documentation of the specific services provided which includes:

1. Name of individual provider.

2. The location for the delivery of services.

3. Units of service.

4. The date, month and year of services and, if applicable, the beginning and ending time of day.

5. Documentation of any changes in the Client's condition or needs, as well as documentation of action taken as a result of the changes.

6. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.02.

7. Documentation of communication with the Client's SEP case manager.

8. Documentation of communication/coordination with other providers.

b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.504.7.A.

v. A copy of the employee's job description.

4. Ensure all care provided is coordinated with any other services the Client is receiving.

**8.504.8 PRIOR AUTHORIZATION REQUESTS**

8.504.8.A. The SEP case manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CLLI waiver.

8.504.8.B. All units of service requested shall be listed on the Support Planning form.

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

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

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

3. The date, on which the Client's parent(s) and/or legal guardian signs the Support Planning form or Intake form, as prescribed by the Department, agreeing to receive services.

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

8.504.8.E. The SEP case manager shall submit a revised PAR if a change in the Support Planning results in a change in services.

8.504.8.F. The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.

8.504.8.G. Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.

8.504.8.H. If services are decreased without the Client's parent(s) and/or legal guardian agreement, the SEP case manager shall notify the Client's parent(s) and/or legal guardian of the adverse action and appeal rights using the LTC 803 form in accordance with the 10 day advance notice period.

**8.504.9 REIMBURSEMENT**

8.504.9.A. Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

## 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.

## 8.506 CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

### 8.506.1 Legal Basis:

The Children's Home and Community -based Services program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CHCBS program is also authorized under state law at Section 25.5-6-901, et seq. C.R.S.

### 8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.506.3.B and the additional operations specifically defined for this waiver in Section 8.506.4.B.

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552

### 8.506.3 General Definitions

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

B. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs. Additional operations specifically defined for this waiver are described in Section 8.506.4.B.

C. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency.

D. Continued Stay Review means a reassessment by the case manager to determine the Client's continued eligibility and functional level of care.

E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital or skilled nursing facility.

F. County Department means the Department of Human or Social Services in the county where the resident resides.

G. Department means the Department of Health Care Policy and Financing.

H. Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.

I. Functional Eligibility means that the Client meets the criteria for long-term care services as determined by the Department's prescribed instrument.

J. Institutional Placement means residing in an acute care hospital or nursing facility.

K. Intake/Screening/Referral means the initial contact with individuals by the Case Management Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

L. 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 a Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements.

M. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery and utilization of services.

M. Professional Medical Information Page (PMIP)Client means the medical information form signed by a licensed medical professional used to certify Level of Care.

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

O. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1

P. Utilization Review Contractor (URC) means the agency or agencies contracted with the Department to review the CHCBS waiver application for confirmation that functional eligibility and targeting criteria are met.

**8.506.4 Benefits**

8.506.4.A Home and Community-based Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at Section 26-1-114, C.R.S.

2. Case Management Agencies will complete all administrative functions of a Client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

    a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of Client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible. 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 Client (e.g. natural disaster, pandemic, etc.

b. At the time of making the initial face-to-face contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective. 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 Client (e.g. natural disaster, pandemic, etc.

c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

d. Verify that the child meets the eligibility requirements outlined in Client Eligibility, Section 8.506.6.

e. Submit the assessment and documentation to the URC to ensure the targeting criteria and functional eligibility criteria are met. Minimum documents required:

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the approved certification to the County Department for activation of a Medicaid State Identification Number.

g. Develop the Support Planning document in accordance with Section 8.506.4.B.7.

i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with Section 8.506.10.

4. Continued Stay Review

a. Complete a new Assessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

b. Submit the assessment and documentation to the URC to ensure the targeting criteria and functional eligibility criteria are met.

c. Review and revise the Support Planning document in accordance with Section 8.506.4.B.7.

d. Notify the county technician of the renewed Long-term Care certification.

5. Discharge/Withdrawal

a. At the time that the Client no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:

i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.

iii. Submit PAR termination to the Department's Fiscal Agent.

iv. Notify County Department of termination.

v. Notify agencies providing services to the Client that the child has been discharged from the waiver.

6. Transfers

a. Sending agency responsibilities:

i. Contact the receiving case management agency by telephone and provide notification that:

1) The child is planning to transfer, per the parent(s) or guardian choice.

2) Negotiate an appropriate transfer date.

3) Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.

ii. Using a State designated form, notify the URC of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.

iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual 9 CCR 2503-5 Section 3.560 Case Transfers.

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, Section 3.560 is available at Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

b. Receiving agency responsibilities

i. Conduct a fact-to-face visit with the child within ten (10) working days of the child's transfer. 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 Client (e.g. natural disaster, pandemic, etc.)., and

ii. Review and revise the Support Planning document and change or coordinate services and providers as necessary.

7. Support Planning

a. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community-based services. A signature from the parent(s) or guardian is required on this state designated form.

b. Documentation that the Client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the Client understands his/her right to change providers

b. On a monthly basis, evaluate the effectiveness of the Support Planning document by monitoring services provided to the child. This monitoring may include:

i. Conducting child, parent(s) or guardian, and provider interviews.

ii. Reviewing utilization data.

iii. Reviewing any written reports received.

8. Performance and Quality Review

a. The Department shall conduct a Performance and Quality Review of the Children's Home and Community-based Services 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 ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but 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 three (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.

8.506.4.C In Home Support Services:

1. IHSS for CHCBS Clients shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.

2. Family members of a Client can only be reimbursed for extraordinary care.

8.506.4.D CHCBS Clients are eligible for all other Medicaid state plan benefits.

**8.506.5 Non-Benefit**

8.506.5.A Tasks defined as Personal Care or Homemaker in Section 8.552 are not benefits of this waiver.

**8.506.6 Client Eligibility**

8.506.6.A An eligible Client shall meet the following requirements:

1. Targeting Criteria:

a. Not have reached his/her eighteenth (18th) birthday.

b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Functional Eligibility:

a. The URC certifies, through the Case Management Agency completed assessment, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.

3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.

4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

8.506.6.B Financial Eligibility

1. Parental income and/or resources will result in the child being ineligible for Medicaid benefits.

2. The income and resources of the child do not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance

3. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, Long-Term Care Medical Assistance Eligibility, Consideration of Trusts in Determining Medicaid Eligibility, Section 8.100.7.E.

8.506.6.C Roles of the County Department

1. Processing the Disability Determination Application through the contracted entity determined by the Department.

2. Certify that the child's income and/or resources does not exceed 300% of SSI.

3. Ensure that the parent(s) or guardian is in contact with a case management agency.

4. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility within five (5) workings days of determination.

**8.506.7 Waiting List**

8.506.7.A The number of Clients who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.

8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

8.506.7.C The waiting list shall be maintained by the URC.

8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the URC will use for the individual's placement on the waiting list.

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the URC will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the URC that an opening for the CHCBS waiver is available the Case Management Agency shall:

1. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

2. Update the existing functional level of care assessment in the official Client record.

3. Reassess for eligibility criteria as set forth at 8.506.6.

4. Notify the URC of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

**8.506.8 Provider Eligibility**

8.506.8.A Providers shall enter into an agreement with the Department to conform to all federal and state established standards for the specific service they provide under the HCBS-CHCBS waiver.

8.506.8.B Providers must comply with the requirements of Section 8.130.

8.506.8.C Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure statute and regulations.

8.506.8.D IHSS providers shall comply with IHSS Rules in Section 8.552.

**8.506.9 Provider Responsibilities**

8.506.9.A CHCBS providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining, and terminating employees;

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to Section 19-3-307 C.R.S.

8.506.9.B CHCBS Providers shall:

1. Ensure a Client is not discontinued or refused services unless documented reasonable efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure Client records and documentation of services are made available at the request of the case manager, Department, or URC.

3. Ensure that adequate records are maintained.

a. Client records shall contain:

i. Name, address, phone number and other identifying information for the Client and the Client's parent(s) and/or legal guardian(s).

ii. Name, address and phone number of child's Case Manager.

iii. Name, address and phone number of the Client's primary physician.

iv. Special health needs or conditions of the Client.

v. Documentation of the specific services provided, including:

a. Name of individual provider.

b. The location for the delivery of services.

c. Units of service.

d. The date, month and year of services and, if applicable, the beginning and ending time of day.

x. Documentation of any changes in the Client's condition or needs, as well as documentation of action taken as a result of the changes.

xi. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.2.

xii. Documentation of communication with the Client's case manager.

xiii. Documentation of communication/coordination with any additional providers.

b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.506.

v. A copy of the employee's job description.

4. Ensure all care provided is coordinated with any other services the Client is receiving.

8.506.9.C Responsibilities specific to IHSS Provider Agencies

1. Eligible IHSS Agencies will conform to all certification standards set forth at 10 C.C.R 2505-10, Section 8.552.5

2. IHSS Agencies will adhere to all responsibilities outlined at 10 C.C.R. 2505.10, Section 8.552.6

3. Ensure that only Health Maintenance Activities are delivered to CHCBS Clients through the IHSS benefit.

8.506.9.D Responsibilities Specific to Case Management Agencies

1. Case Management Agencies will obtain a specific authorization to provide CHCBS case management benefits to Clients as set forth in Provider Enrollment Section 8.487.

2. Verify that the IHSS care plan developed by IHSS providers is in accordance with both Sections 8.506.4.C and 8.552 of this volume.

3. Case Management Agencies must submit all documentation requested by the Department to complete a Performance and Quality Review within the timeframe specified by the Department.

**8.506.10 Prior Authorization Requests**

8.506.10.A The Case Manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the Support Planning document.

8.506.10.C The first date for which services can be authorized is the latest date of the following:

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

2. The assigned start date on the certification page of the Assessment.

3. The date, on which the Client's parent(s) and/or legal guardian signs the Support Planning document or Intake form, as prescribed by the Department, agreeing to receive services.

8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Assessment.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Support Planning document results in a change in services.

8.506.10.F The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.

8.506.10.G Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.

8.506.10.H The Long-Term Care Notice of Action Form (LTC-803) shall be completed in the Information Management System (IMS) (as defined at 8.519.1.Z) for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, or at the time of discontinuation.

**8.506.11 Reimbursement**

8.506.11.A Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

**8.506.12 Cost Containment**

8.506.12.A The Department is responsible for ensuring that, on average, services delivered to the child are within the Department's cost containment requirements for the respective level of institutional care. Cost Containment includes;

1. Waiver benefit services and units, as defined at 8.506.2.

2. State Plan benefit services and units.

8.506.12.B The case manager must ensure cost effectiveness as part of the Support Planning process.

8.506.12.C The costs of the benefit services shall be totaled and divided by the number of days remaining before the end of the child's current enrollment period.

8.506.12.D The cost per day for the child shall be compared against the Department designated cost per day of institutional care to determine cost effectiveness.

## 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 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

### 8.508.10 LEGAL BASIS

The Home and Communitybased Services- Children's Habilitation Residential Program (HCBS-CHRP) is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a. The waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n.

### 8.508.20 DEFINITIONS

A. Abuse: As defined at § 16-22-102 (9) C.R.S., § 19-1-103, C.R.S., § 25.5-10-202 (1) (a)-(c), C.R.S., and § 26.3.1-101 C.R.S.

B. Adverse Action: A denial, reduction, termination, or suspension from a Long-Term Services and Supports (LTSS) program or service.

C. Applicant: A child or youth who is seeking a Long-Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. Caretaker: As defined at Section 25.5-10-202 (1.6)(a)-(c), C.R.S.

E. Caretaker neglect: As defined at Section 25.5-10-202 (1.8)(a)-(c), C.R.S.

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

G. Child Placement Agency: As defined at 12 CCR 2509-8; Section 7.701.2 (F).

H. Client: A child or youth who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-based Services (HCBS)

I. Client Representative: A person who is designated to act on the Client's behalf. A Client Representative may be: (a) a legal representative including, but not limited to a court-appointed guardian, or a parent of a minor child; or (b) an individual, family member or friend selected by the Client to speak for an/or act on the Client's behalf.

J. Community Centered Board: A private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-based Service waivers specific to individuals with intellectual and developmental disabilities, and management of state funded programs for individuals with intellectual and developmental disabilities.

K. Complex Behavior: Behavior that occurs related to a diagnosis by a licensed physician, psychiatrist, or psychologist that includes one or more substantial disorders of the cognitive, volitional or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior.

L. Complex Medical Needs: Needs that occur as a result of a chronic medical condition as diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12) months, requires skilled care, and that without intervention may result in a severely life altering condition.

M. Comprehensive Assessment: An initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support.

N. Cost Containment: Limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-based Services, and Medicaid State Plan benefits including long- term home health services and targeted case management.

O. Criminal Activity: A criminal offense that is committed by a person; a violation of parole or probation; and any criminal offense that is committed by a person receiving services that results in immediate incarceration.

P. Crisis: An event, series of events, and/or state of being greater than normal severity for the Client and/or family that becomes outside the manageable range for the Client and/or their family and poses a danger to self, family, and/or the community. Crisis may be self-identified, family identified, and/or identified by an outside party.

Q. Critical Incident: Incidents of Mistreatment; Abuse; Neglect; Exploitation, Criminal Activity; Damage to Client's Property/Theft; Death unexpected or expected; Injury/Illness to Client; Medication Mismanagement; Missing Person; Unsafe Housing/Displacement; and/or Other Serious Issues.

R. Department: The Colorado Department of Health Care Policy and Financing the single state Medicaid agency.

S. Damage to Client's Property/Theft: Deliberate damage, destruction, theft or use a Client's belongings or money. If the incident involves Mistreatment by a Caretaker that results in damage tor Client's property or theft in the incident shall be listed as Mistreatment.

T. Developmental Delay: A child who is:

1. Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:

    i. Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age;

    ii. Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development;

    iii. Has an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or

2. Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a CCB.

U. Early and Periodic Screening Diagnosis and Treatment (EPSDT): As defined in Section 8.280.1.

V. Exploitation: As defined in Sections 25.5-10-202(15.5)(a)-(d) and 26.3.1-101 C.R.S.

W. Extraordinary Needs: A level of care due to Complex Behavior and/or Medical Support Needs that is provided in a residential child care facility or that is provided through community-based programs, and without such care, would place a child at risk of unwarranted child welfare involvement or other system involvement.

X. Family: As defined at Section 25.5-10-202 (16)(a)(I)-(IV)(b), C.R.S.

Y. Foster Care Home: A family care home providing 24-hour care for a child or children and certified by either a County Department of Social/Human Services or a child placement agency. A Foster Care Home, for the purposes of this waiver, shall not include a family member as defined in Section 25.10-202 (16)(a)(I)-(IV)(b), C.R.S.

Z. Guardian: An individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not guardian ad litem.

AA. Guardian ad litem or GAL: A person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the “School Attendance Law of 1963”, set forth in Article 33 of Title 22, C.R.S.

BB. Harmful Act: as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.

CC. Home and Community-based Services (HCBS) Waivers: Services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

DD. Increased Risk Factors: Situations or events that when occur at a certain frequency or pattern historically have led to Crisis.

EE. Informed Consent: An assent that is expressed in writing, freely given, and preceded by the following:

1. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

2. A description of the attendant discomforts and risks;

3. A description of the expected benefits;

4. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

5. An offer to answer any inquiries regarding the procedure(s);

6. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

7. A statement that withholding or withdrawal of consent shall not prejudice future availability of services and supports.

FF. Injury/Illness to Client: An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, and skin wounds; an injury or illness requiring immediate emergency medical treatment to preserve life or limb; an emergency medical treatment that results in admission to the hospital; and a psychiatric crisis resulting in unplanned hospitalization.

GG. Institution: A hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the State Plan.

HH. Intellectual and Developmental Disability: A disability that manifests before the person reaches twenty-two (22) years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of “developmental disability” found in 42 U.S.C. sec. 15001 et seq., does not apply.

“Impairment of general intellectual functioning” The person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. when an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

“Adaptive behavior similar to that of a person with intellectual and developmental disabilities” The person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

“Substantial intellectual deficits” An intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

II. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID): A publicly or privately-operated facility that provides health and habilitation services to a Client with intellectual or developmental disabilities or related conditions.

JJ. Kin: As defined in 12 CCR 2509-1, Section 7.000.2.A.

KK. Kinship Foster Care Home: As defined in 12 CCR 2509-1, Section 7.000.2.A.

LL. Level of Care (LOC): The specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

MM. Level of Care Determination: An eligibility determination by a CCB of an Individual for a Long-Term Services and Supports (LTSS) program.

NN. Level of Care Evaluation: A comprehensive evaluation with the Individual seeking services and others chosen by the Individual to participate, conducted by the case manager utilizing the Department's prescribed tool, with supporting diagnostic information from the Individual's medical providers, for the purpose of determining the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports (LTSS) programs.

OO. Licensed Child Care Center (less than 24 hours): As defined in Section 26-6-102 (5), C.R.S. and as described in 12 CCR 2509-8; Section 7.701.

PP. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Clients of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

QQ. Medicaid Eligible: The Applicant or Client meets the criteria for Medicaid benefits based on the financial determination and disability determination.

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

SS. Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

TT. Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or there is a risk to public safety.

UU. "Mistreated" or "Mistreatment": As defined at Section 25.5-10-202(29.5)(a)-(d) and 26.3.1-101.

VV. Natural Supports: Unpaid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

WW. Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.

XX. Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or lesser likelihood of success of Crisis interventions.

YY. Prior Authorization: Approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the CMA.

ZZ. Professional: Any person, not including family, performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

AAA. Professional Medical Information Page (PMIP): The medical information form signed by a Licensed Medical Professional used to certify Level of Care.

BBB. Relative: A person related to the Client by blood, marriage, adoption or common law marriage.

CCC. Residential Child Care Facility: As defined in 12 CCR 2509-8, Section 7.705.1.

DDD. Retrospective Review: The Department's review after services and supports are provided to ensure the Client received services according to the service plan and standards of economy, efficiency and quality of service.

EEE. Separation: The restriction of a Client for a period of time to a designated area from which the is not physically prevented from leaving, for the purpose of providing the Client an opportunity to regain self-control.

FFF. Service Provider: A Specialized Group Facility, Residential Child Care Facility, Foster Care Home, Kinship Foster Care Home, Child Placement Agency, Licensed Child Care Facility (non-24 hours), and/or Medicaid enrolled provider.

GGG. Service Plan: The written document that specifies identified and needed services, to include Medicaid and non-Medicaid covered services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with Department regulations.

HHH. Service Planning: The process of working with the Client receiving services and people chosen by the Individual, to identify goals, needed services, and appropriate service providers based on the Comprehensive Assessment and knowledge of the available community resources. Service planning informs the Individual seeking or receiving services of his or her rights and responsibilities.

III. Specialized Group Facility: As defined in 12 CCR 2509-8; Section 7.701.2(B).

JJJ. Support: Any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

KKK. Support Level: A numeric value determined by the Support Need Level Assessment that places Clients into groups with other Clients who have similar overall support needs.

LLL. Support Need Level Assessment: The standardized assessment tool used to identify and measure the support requirements for HCBS-CHRP waiver participants.

MMM. Targeted Case Management (TCM): Has the same meaning as in Section 8.761.

NNN. Third Party Resources: Services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to community resources, services provided through private insurance, non-profit services and other government programs.

OOO. Unsafe Housing/Displacement: An individual residing in an unsafe living condition due to a natural event (such as fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.

PPP. Waiver Service: Optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

QQQ. Wraparound Facilitator: A person who has a bachelor's degree in a human behavioral science or related field of study and is certified in a wraparound training program. Experience working with LTSS populations in a private or public social services agency may substitute for the bachelor's degree on a year for year basis. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field. The wraparound certification must include training in the following:

Trauma informed care.

Youth mental health first aid.

Crisis supports and planning.

Positive Behavior Supports, behavior intervention, and de-escalation techniques.

Cultural and linguistic competency.

Family and youth serving systems.

Family engagement.

Child and adolescent development.

Accessing community resources and services.

Conflict resolution.

Intellectual and developmental disabilities.

Mental health topics and services.

Substance abuse topics and services.

Psychotropic medications.

Motivational interviewing.

Prevention, detection, and reporting of Mistreatment, Abuse, Neglect, and Exploitation.

RRR. Wraparound Transition Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a transition to the family home after out of home placement.

SSS. Wraparound Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a plan to maintain stabilization, prevent Crisis, and/or for de-escalation of Crisis situations.

TTT. Wraparound Support Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

UUU. Wraparound Transition Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

**8.508.30 SCOPE OF SERVICES**

A. The HCBS-CHRP waiver provides services and supports to eligible children and youth with Intellectual and Developmental Disability, and who are at risk of institutionalization pursuant to 25.5-6-903, C.R.S. The services provided through this waiver serve as an alternative to ICF/IID placement for children from birth to twenty-one years (21) of age who meet the eligibility criteria and the Level of Care as determined by a Level of Care Evaluation and Determination. The services provided through the HCBS-CHRP waiver are limited to:

1. Habilitation
2. Hippotherapy
3. Intensive Support
4. Massage Therapy
5. Movement Therapy
6. Respite
7. Supported Community Connection
8. Transition Support

B. HCBS-CHRP waiver services shall be provided in accordance with these rules and regulations.

**8.508.40 ELIGIBILITY**

A. Services shall be provided to Clients with an Intellectual and Developmental Disability who meet all of the following eligibility requirements:

1. A determination of developmental disability by a CCB which includes developmental delay if under five (5) years of age.
2. The Client has Extraordinary Needs that put the Client at risk of, or in need of, out of home placement.
3. Meet ICF-IID Level of Care as determined by a Level of Care Evaluation.
4. The income of the Client does not exceed 300% of the current maximum SSI standard maintenance allowance.
5. Enrollment of the Client in the HCBS- CHRP waiver will result in an overall savings when compared to the ICF/IID cost as determined by the State.
6. The Client receives at least one waiver service each month.

B. 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 and per diem Respite services.

C. Clients must first access all benefits available under the Medicaid State Plan and/or EPSDT for which they are eligible, prior to accessing funding for those same services under the HCBS-CHRP waiver.

D. Pursuant to the terms of the HCBS-CHRP waiver, the number of individuals who may be served each year is based on:

1. The federally approved capacity of the waiver;

2. Cost Containment requirements under section 8.508.80;

3. The total appropriation limitations when enrollment is projected to exceed spending authority.

**8.508.50 WAITING LIST PROTOCOL**

A. Clients determined eligible for HCBS-CHRP services who cannot be served within the appropriation capacity limits of the HCBS-CHRP waiver shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the Client's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.508.40 were determined to have been met and the Department was notified.

3. As openings become available within the appropriation capacity limits of the federal waiver, Clients shall be considered for services based on the date of their waiting list placement.

**8.508.60 RESPONSIBILITIES OF THE CCB**

A. The CCB shall make eligibility determinations for developmental disabilities services to include the Level of Care Evaluation Determination for any Applicant or Client being considered for enrollment in the HCBS-CHRP waiver.

B. Additional administrative responsibilities of CCBs as required in 8.601.

**8.508.70 CASE MANAGEMENT FUNCTIONS**

A. Case management services will be provided by a CMA as a Targeted Case Management service pursuant to sections 8.761.14 and 8.519 and will include:

1. Completion of a Comprehensive Assessment;

2. Completion of a Service Plan (SP);

3. Referral for services and related activities;

4. Monitoring and follow-up by the CMA including ensuring that the SP is implemented and adequately addresses the Client's needs.

5. Monitoring and follow-up actions, which shall

a. Be performed when necessary to address health and safety and services in the SP;

b. Services in the SP are adequate; and

c. Necessary adjustments in the SP and service arrangements with providers are made if the needs of the Client have changed.

6. Face to face monitoring to be completed at least once per quarter and to include direct contact with the Client in a place where services are delivered. Upon Department approval, monitoring 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 Client (e.g. natural disaster, pandemic, etc.).

**8.508.71 SERVICE PLAN (SP)**

A. The CMA shall complete a Service Plan for each Client enrolled in the HCBS-CHRP waiver in accordance with Section 8.519.11.B and will:

1. Address the Client's assessed needs and personal goals, including health and safety risk factors either by HCBS-CHRP waiver services or any other means;

2. Be in accordance with the Department's rules, policies, and procedures;

3. Be entered and verified in the Department prescribed system within ten (10) business days;

4. Describe the types of services to be provided, the amount, frequency, and duration of each service and the provider type for each service;

5. Include a statement of agreement by the Client and/or the legally responsible party; and

6. Be updated or revised at least annually or when warranted by changes in the Client's needs.

B. The Service Plan shall document that the Client has been offered a choice:

1. Between HCBS waivers and institutional care;

2. Among HCBS-CHRP waiver services; and

3. Among qualified providers.

**8.508.72 PRIOR AUTHORIZATION REQUESTS (PAR)**

A. The case manager shall submit a PAR in compliance with applicable regulations and ensure requested services are:

1. Consistent with the Client's documented medical condition and Comprehensive Assessment.

2. Adequate in amount, frequency, scope and duration in order to meet the Client's needs and within the limitations set forth in the current federally approved HCBS-CHRP waiver.

3. Not duplicative of another service, including services provided through:

a. Medicaid State Plan benefits;

b. Third Party Resources;

c. Natural Supports;

d. Charitable organizations; or

e. Other public assistance programs.

B. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to Section 8.058.4.

**8.508.73 REIMBURSEMENT**

A. Only services identified in the Service Plan are available for reimbursement under the HCBS-CHRP waiver. Reimbursement will be made only to licensed or certified providers, as defined in Section 8.508.160 and services will be reimbursed per a fee for service schedule as determined by the Department through the Medicaid Management Information System (MMIS).

B. Only those services not available under Medicaid EPSDT, Medicaid State Plan benefits, Third Party Resources, or other public funded programs, services or supports are available through the CHRP Waiver. All available community services must be exhausted before requesting similar services from the waiver. The CHRP Waiver does not reimburse services that are the responsibility of the Colorado Department of Education.

C. 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 Client or to meet the requirements of the applicable life safety code.

D. Medicaid shall not pay for room and board.

E. Claims for Targeted Case Management are reimbursable pursuant to Section 8.761.4-.5.

**8.508.74 COMPLIANCE MONITORING**

A. Services provided to a Client are subject to compliance monitoring by the Department pursuant to Section 8.076.2.

**8.508.80 COST CONTAINMENT**

Cost Containment is to ensure, on an individual Client basis, that the provision of HCBS-CHRP services is a cost-effective alternative compared to the equivalent cost of appropriate ICF/IID institutional Level of Care. The Department shall be responsible for ensuring that, on average, each Service Plan is within the federally approved Cost Containment requirements of the waiver. Clients enrolled in the HCBS-CHRP waiver shall continue to meet the Cost Containment criteria during subsequent periods of eligibility.

**8.508.100 SERVICE DESCRIPTIONS**

A. Habilitation

1. Services may be provided to Clients who require additional care for the Client to remain safely in home and community-based settings. The Client must demonstrate the need for such services above and beyond those of a typical child of the same age.

2. Habilitation services include those that assist Clients in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

3. Habilitation services under the HCBS-CHRP waiver differ in scope, nature, supervision, and/or provider type (including provider training requirements and qualifications) from any other services in the Medicaid State Plan.

4. Habilitation is a twenty-four (24) hour service and includes the following activities:

   a. Independent living training, which may include personal care, household services, infant and childcare when the Client 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.

   c. Cognitive services which includes assistance with additional concepts and materials to enhance communication.

   d. Emergency assistance which includes safety planning, fire and disaster drills, and crisis intervention.

   e. Community access supports which includes assistance developing the abilities and skills necessary to enable the Client 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 the Client's Service Plan. These activities are conducted in a variety of settings in which the Client interacts with non-disabled individuals (other than those individuals who are providing services to the Client). These services may include socialization, adaptive skills, and personnel to accompany and support the individual 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 Client.

   f. 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 are more specific to supports provided by Foster Care Homes, Kinship Foster Care Homes, Specialized Group Facilities, and Residential Child Care Facilities to access activities and functions of community life.

   g. 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.

   h. Medical and health care services that are integral to meeting the daily needs of the Client and include such tasks as routine administration of medications or providing support when the Client is ill.

5. 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.

6. Habilitation may be provided for clients age eighteen (18) to twenty (20) in a Host Home. The Host Home must meet all requirements as defined in Section 8.600.

7. Service Providers and child placement agencies must not exceed habilitation capacity limits at 12 CCR 2509-8; §§ 7.701.2, 7.708.1.A.2, 7.710.48.C.

8. Only one (1) HCBS-CHRP Client and two (2) HCBS- Persons with Developmental Disabilities (DD) or HCBS- Supported Living Services (SLS) waiver participants; or two (2) HCBS-CHRP participants and one HCBS-DD or HCBS-SLS waiver participant may live in the same foster care home.

9. The Service Provider or child placement agency shall ensure choice is provided to all Clients in their living arrangement.

10. The Foster Care Home or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all Clients living in the home.

11. The Service Provider shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification before any child or youth can be placed in that home. If emergency placement is needed outside of business hours, the Service Provider or child placement agency shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification the next business day.

B. Hippotherapy

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

2. Hippotherapy may be provided only when the provider is licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

3. Hippotherapy must be used as a treatment strategy for an identified medical or behavioral need.

4. Hippotherapy must be an identified need in the Service Plan.

5. Hippotherapy must be recommended or prescribed by a licensed physician or therapist who is enrolled as a Medicaid provider. The recommendation must clearly identify the need for hippotherapy, recommended treatment, and expected outcome.

6. The recommending therapist or physician must monitor the progress of the hippotherapy treatment at least quarterly.

7. Hippotherapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT, or from a Third-Party Resource.

8. Equine therapy and therapeutic riding are excluded.

C. Intensive Support

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

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

3. Intensive support services include:

   a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the child or youth and family.

   b. Identification of needs for Crisis prevention and intervention including, but not limited to:

      i. Cause(s) and triggers that could lead to a Crisis.

      ii. Physical and behavioral health factors.

      iii. Education services.

      iv. Family dynamics.

      v. Schedules and routines.

      vi. Current or history of police involvement.

      vii. Current or history of medical and behavioral health hospitalizations.

      viii. Current services.

      ix. Adaptive equipment needs.

      x. Past interventions and outcomes.

      xi. Immediate need for resources.

      xii. Respite services.

      xiii. Predictive Risk Factors.

      xiv. Increased Risk Factors.

4. 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 Client 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 Client emotionally and behaviorally and to decrease the frequency and duration of any future behavioral Crises.

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 Client has stabilized.

n. Contingency plan for out of home placement.

o. Coordination among 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.

5. Child and Youth Mentorship.

a. The type, frequency, and duration of in-home support services must be included in a Wraparound Plan.

b. Child and Youth Mentorship includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the child or youth with self-care, learning self-advocacy, and protective oversight.

c. Service may be provided in the Client's home or community as determined by the Wraparound Plan.

6. Follow-up services.

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

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

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

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

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

7. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the Client, their Family, and their Wraparound Support Team.

8. All service and supports providers on the Wraparound Support Team must adhere to the Wraparound Plan.

9. Revision of strategies should be a continuous process by the Wraparound Support Team in collaboration with the Client, until the Client is stable and there is no longer a need for Intensive Support Services.

10. On-going evaluation after completion of the Wraparound Plan may be provided if there is a need to support the Client and his or her Family in connecting to any additional resources needed to prevent a future Crisis.

D. Massage Therapy

1. Massage therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation, and muscle tension including WATSU.

2. Children with specific developmental disorders often experience painful muscle contractions. Massage has been shown to be an effective treatment for easing muscle contracture, releasing spasms, and improving muscle extension, thereby reducing pain.

3. Massage therapists must be licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

4. The service must be used as a treatment strategy for an identified medical or behavioral need and included in the Service Plan.

5. Massage therapy services must be recommended or prescribed by a therapist or physician who is an enrolled Medicaid Provider. The recommendation must include the medical or behavioral need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the massage therapy treatment at least quarterly.

6. Massage therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.

E. Movement Therapy

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.

2. Movement therapy providers must be meet the educational requirements and is certified, registered and/or accredited by an appropriate national accreditation association.

3. Movement therapy is only authorized as a treatment strategy for a specific medical or behavioral need and identified in the Client's Service Plan.

4. Movement therapy must be recommended or prescribed by a therapist or physician who is enrolled Medicaid provider. The recommendation must include the medical need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the movement therapy at least quarterly.

5. Movement Therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.

F. Respite

1. Respite services are provided to children or youth living in the Family home on a short-term basis because of the absence or need for relief of the primary Caretaker(s)

2. Respite services may be provided in a certified Foster Care Home, Kinship Foster Care Home, Licensed Residential Child Care Facility, Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours), in the Family home, or in the community.

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

4. The total amount of respite provided in one Service 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 client's age, disability or unique family circumstances.

5. 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.

6. Respite is available for children or youth living in the Family home and may not be utilized while the Client is receiving Habilitation services.

G. Community Connector

1. Community Connector services are provided one-on-one to deliver instruction for documented Complex Behavior that are exhibited by the Client while in the community, such as physically or sexually aggressive behavior towards others and/or exposing themselves.

2. Services must be provided in a setting within the community where the Client interacts with individuals without disabilities (other than the individual who is providing the service to the Client).

3. The targeted behavior, measurable goal(s), and plan to address must be clearly articulated in the Service Plan.

4. This service is limited to 260 hours or 1040 units per year.

5. A request to increase service hours can be made to the Department on a case-by-case basis.

H. Transition Support

1. Transition support services align strategies, interventions, and Supports for the Client, and Family, when a Client transitions to the Family home from out-of-home placement.

2. Services include:

a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and Family.

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

i. Cause(s) of a Crisis and triggers that could lead to a Crisis.

ii. Physical and behavioral health factors.

iii. Education services.

iv. Family dynamics.

v. Schedules and routines.

vi. Current or history of police involvement.

vii. Current or history of medical and behavioral health hospitalizations.

viii. Current services.

ix. Adaptive equipment needs.

x. Past interventions and outcomes.

xi. Immediate need for resources.

xii. Respite services.

xiii. Predictive Risk Factors.

xiv. Increased Risk Factors.

3. Development of a Wraparound Transition Plan is required, with action steps to implement strategies to address identified transition risk factors including, but not limited to:

a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and Family.

b. Environmental modifications.

c. Strategies for transition risk factors.

d. Strategies for avoiding Crisis triggers.

e. Support needs in the Family home.

f. Respite services.

g. Learning new adaptive or life skills.

h. Counseling/behavioral or other therapeutic interventions to further stabilize the Client emotionally and behaviorally to decrease the frequency and duration of future Crises.

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. Identification of strategies to achieve and maintain stabilization in the Family home.

m. Identification of how the Wraparound Plan will terminate once the child or youth has stabilized.

n. Coordination among Family, service providers, natural supports, professionals, and case managers required to implement the Wraparound Transition Plan.

o. Dissemination of a Wraparound Transition Plan to all involved in plan implementation.

4. Child and Youth Mentorship

a. The type, frequency, and duration of authorized services must be included in the Wraparound Plan.

b. Child and Youth Mentorship includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the Client with self-care, learning self-advocacy, and protective oversight.

c. Services may be provided in the Client's home or in community, as provided in the Wraparound Transition Plan.

5. Follow-up services are authorized and may include:

a. Evaluation to ensure the Wraparound Transition Plan is effective in the Client achieving and maintaining stabilization in the Family home.

b. Evaluation of the Wraparound Transition plan to occur at a frequency determined by the Client's needs and includes but is not limited to, visits to the Client's home, review of documentation, and coordination with other professionals and/or members of the Wraparound Transition Support Team to determine progress.

c. Reviews of the Client's stability and monitoring of Predictive Risk Factors that could indicate a return to Crisis.

d. Revision of the Wraparound Plan as needed to avert a Crisis or Crisis escalation.

e. Ensuring that follow-up appointments are made and kept.

6. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the Client, their family, and their Wraparound Transition Team.

7. All service providers and supports on the Wraparound Transition Team must adhere to the Wraparound Transition Plan.

8. Revision of strategies should be a continuous process by the Wraparound Transition Team in collaboration with the Client, until stabilization is achieved and there is no longer a need for Transition Support Services.

9. On-going evaluation after completion of the Wraparound Transition Plan may be provided based on individual needs to support the Client and their family in connecting to any additional resources needed to prevent future Crisis or out of home placement.

**8.508.101 USE OF RESTRAINTS**

A. The definitions contained at 12 CCR 2509-8; Section 7.714.1 (2019) are hereby incorporated by reference. The definition for "Client Representative" in 12 CCR 2509-8, Section.7.714.1 is specifically excluded. The incorporation of these regulations excludes later amendments to the regulations. 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. Copies of incorporated materials are provided at cost upon request.

B. Service Providers shall comply with the requirements for the use of Restraints in 12 CCR 2509-8, Sections 7.714.53 through 7.714.537, (2019) which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. 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. Copies of incorporated materials are provided at cost upon request.

C. All records of restraints shall be reviewed by a supervisor of the Service Provider within 24 hours of the incident. If it appears that the Client has been restrained excessively, frequently in a short period of time, or frequently by the same staff member, the Client's Service Plan must be reviewed.

D. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of restraints in Sections 8.608.2, 3, & 4 for Clients receiving Habilitation services age eighteen (18)- twenty (20).

**8.508.102 RIGHTS MODIFICATIONS**

A. Cruel and aversive therapy, or cruel and unusual discipline is prohibited.

B. Service Providers shall comply with the requirements for Client Rights in 12 CCR 2509-8; Section 7.714.52 (2019) is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. 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. Copies of incorporated materials are provided at cost upon request.

C. Rights modifications are based on the specific assessed needs of the child or youth, not the convenience of the provider.

D. Rights modifications may only be imposed if the Client poses a danger to self, Family, and/or the community.

E. The case manager is responsible for obtaining Informed Consent and other documentation supporting any rights modifications/limitations and must maintain these materials in their file as a part of the Service Plan.

F. Any rights modification must be supported by a specific assessed need and justified in the Service Plan. The following must be documented in the Service Plan:

1. Identification of a specific and individualized need.

2. Documentation of the positive interventions and supports used prior to any modifications Service Plan.

3. Documentation of less intrusive methods of meeting the Client's needs that have been tried, and the outcome.

4. A description of the rights modification to be used that is directly proportionate to respond to the specific assessed need.

5. The collection and review of data used to measure the ongoing effectiveness of the modification.

6. Established time limits for periodic reviews, no less than every six (6) months, to determine if the modification is still necessary or if it can be terminated.

7. The Informed Consent of the Individual.

8. An assurance that interventions and Support will cause no harm to the Individual.

G. Specialized Group Facilities, Foster Care Homes, Kinship Foster Care Home, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours), and Child Placement Agencies must also ensure compliance with the Colorado Department Human Services rules regarding the use of restrictive interventions at 12 CCR 2509-8.

H. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of rights modifications at § 8.604.3 and for Clients receiving Habilitation services age eighteen (18)- twenty (20).

**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).

**8.508.110 MAINTENANCE OF CASE RECORDS**

A. CMAs shall maintain all documents, records, communications, notes and other materials for all work performed related to HCBS-CHRP. CMAs shall maintain records for six (6) years after the date a Client discharges from a waiver program.

**8.508.121 REASSESSMENT AND REDETERMINATION OF ELIGIBILITY**

A. The CMA shall conduct a Level of Care Evaluation and Determination to redetermine or confirm a Client's eligibility for the HCBS-CHRP waiver, at a minimum, every twelve (12) months.

B. The CMA shall conduct a Comprehensive Assessment to redetermine or confirm a Client's individual needs, at a minimum, every twelve (12) months.

C. The CMA shall verify that the child or youth remains Medicaid Eligible at a minimum, every twelve (12) months.

**8.508.140 DISCONTINUATION FROM THE HCBS- CHRP WAIVER**

A. A Client shall be discontinued from the HCBS-CHRP waiver when one of the following occurs:

1. The Client no longer meets the criteria set forth in Section 8.508.40;

2. The costs of services and supports provided in the community exceed the Cost Effectiveness exceeds ICF-IID costs;

3. The Client enrolls in another HCBS waiver program or is admitted for a long-term stay beyond 30 consecutive days in an Institution; or

4. The Client reaches his/her 21st birthday.

5. The Client does not receive a waiver service during a full one-month period.

**8.508.160 SERVICE PROVIDERS**

A. Service providers for habilitation services and services provided outside the Family home shall meet all of the certification, licensing and quality assurance regulations related to their provider type (Respite Service providers that provide community connector, movement therapy, massage therapy, hippotherapy, intensive support, and transition support in the family home must:

1. Meet the required qualifications as defined in the federally approved HCBS-CHRP waiver.

2. Maintain and abide by all the terms of their Medicaid Provider Agreement and section 8.130.

3. Comply with all the provisions of this Section 8.508; and

4. Have and maintain any required state licensure.

B. Service providers shall maintain liability insurance in at least such minimum amounts as set annually by the Department.

C. A Family member may not be a Service Agency for another Family member. A Family member may be reimbursed for certain services as approved in the waiver.

D. Service Providers shall not discontinue or refuse services to a Client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

E. Service Providers must have written policies that address the following:

1. Access to duplication and dissemination of information from the child's or youth's records in compliance with all applicable state and federal privacy laws.

2. How to response to alleged or suspected abuse, mistreatment, neglect, or exploitation. The policy must require immediate reporting when observed by employees and contractors to the agency administrator or designee and include mandatory reporting requirements pursuant to Sections 19-3-304 and 18-6.5-108, C.R.S.

3. The use of restraints, the rights of Client's, and rights modifications pursuant to sections 8.508.101 and 8.508.102.

4. Medication administration pursuant to Section 8.508.103.

5. Training employees and contractors to enable them to carry out their duties and responsibilities efficiently, effectively and competently. The policy must include staffing ratios that are sufficient to meet the individualized support needs of each Client receiving services.

6. Emergency procedures including response to fire, evacuation, severe weather, natural disasters, relocation, and staffing shortages.

F. Service Provides must maintain records to substantiate claims for reimbursement in accordance with Department regulations and guidance.

G. Service Providers must comply with all federal and state program reviews and financial audits of HCBS-CHRP waiver services.

H. Service Providers must comply with requests by the Department to collect, review, and maintain individual or agency information on the HCBS-CHRP waiver.

I. Service Providers must comply with requests by the CMA to monitor service delivery through Targeted Case Management.

**8.508.165 TERMINATION OR DENIAL OF HCBS-CHRP MEDICAID PROVIDER AGREEMENTS**

A. The Department may deny or terminate an HCBS-CHRP waiver Medicaid provider agreement in accordance with Section 8.076.5.

**8.508.180 CLIENT'S RIGHTS**

A. Service Providers shall comply with the requirements for Client's Rights in 12 CCR 2509-8; Section 7.714.31 (2019) which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to Section 24-4-103(12.5), 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. Copies of incorporated materials are provided at cost upon request.

B. Every Client has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, gender identity, political affiliation, sexual orientation, financial status or disability.

C. Every Client has the right to access age appropriate forms of communication including text, email, and social media.

D. No Client, his/her Family members, Guardian or Client Representative may be retaliated against in their receipt of services or supports as a result of attempts to advocate on their own behalf.

E. Each Client receiving services has the right to read or have explained in each Client's and Family's native language, any policies and/or procedures adopted by the Service Agency.

F. Host Homes and Service Providers contracting with Host Home Providers must comply with the procedural requirements regarding rights at § 8.604.2 for Clients receiving Habilitation services age eighteen (18)- twenty (20).

**8.508.190 APPEALS**

A. The CCB shall provide a Long-Term Care notice of action form (LTC 803) to Applicants and Clients and their parent(s) or Guardian in accordance with section 8.057 when:

1. The Applicant is determined not to have a developmental delay or developmental disability,

2. The Applicant is determined eligible or ineligible for Long-Term Services and Supports (LTSS),

3. The Applicant is determined eligible or ineligible for placement on a waiting list for LTSS services,

4. An Adverse Action occurs that affects the Client's waiver enrollment status.

B. The CCB shall appear and defend its decision at the Office of Administrative Courts.

C. The CCB shall notify the Case Management Agency in the Client's Service Plan within one (1) business day of the Adverse Action.

D. The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business days of an Adverse Action that affects Medicaid financial eligibility.

E. The CCB shall notify the applicant's parent or Guardian of an Adverse Action if the applicant or Client is determined ineligible for any reason including if:

1. The Client is detained or resides in a correctional facility for at least one day, and

2. The Client enters an institute for mental health for a duration greater than thirty (30) days.

F. The CMA shall provide the Long-Term Care notice of action form to Clients in accordance with section 8.507 when:

1. An Adverse Action occurs that affects the Client's waiver services, or

G. The CMA shall notify all providers in the Client's Service Plan within one (1) business days of the Adverse Action.

1. The CMA shall notify the county Department of Human/Social Services income maintenance technician within ten (10) business days of an Adverse Action that may affect financial eligibility for HCBS waiver services.

H. The applicant or Client shall be informed of an Adverse Action if the applicant or Client is determined to be ineligible as set forth in the waiver- specific Client eligibility criteria and the following:

1. The Client cannot be served safely within the Cost Containment identified in the HCBS waiver,

2. The Client is placed in an Institution for treatment for more than thirty (30) consecutive days,

3. The Client is detained or resides in a correctional facility for at least one day, or

4. The Client enters an institute for mental health for more than thirty (30) consecutive days.

I. The Client shall be notified, pursuant to section 8.057.2. when the following results in an Adverse Action that does not relate to waiver Client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the Level of Care Evaluation and Determination

2. A Service Plan or waiver service exceeds the limits set forth in the federally approved waiver.

3. The Client is being terminated from HCBS due to a failure to attend a Level of Care assessment appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

4. The Client is being terminated from HCBS due to a failure to attend a Service Plan appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

5. The Client enrolls in a different LTSS program.

6. The Client moves out of state. The Client shall be discontinued effective the day after the date of the move.

    a. A Client who leaves the state on a temporary basis, with intent to return to Colorado, pursuant to Section 8.100.3.B.4, shall not be terminated unless one or more of the Client eligibility criteria are no longer met.

J. If a Client voluntarily withdraws from the waiver, the termination shall be effective the day after the date the s the request was made by the Client

1. The case manager shall review with the Client their decision to voluntarily withdraw from the waiver. The Case Manager shall not send a notice of action, upon confirmation of withdraw.

K. The CMA shall not send a Long-Term Care notice of action form when the basis for termination is death of the Client but shall document the event in the Client record. The date of action shall be the day after the date of death.

L. The CMA shall appear and defend its decision at the Office of Administrative Courts when the CMA has issued an Adverse Action.

## 8.509 HOME AND COMMUNITY-BASED SERVICES FOR COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS)

### 8.509.10 GENERAL PROVISIONS

### 8.509.11 LEGAL BASIS

A. The Home and Community-based Services for COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS) program in Colorado is authorized by a waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CMHS program is also authorized under state law at Sections 25.5-6-601 through 25.5-6-607, C.R.S. The number of recipients served in the HCBS-CMHS program is limited to the number of recipients authorized in the waiver.

B. All congregate facilities where any HCBS Client resides must be in possession of a valid Assisted Living Residence license issued under Section 25-27-105, C.R.S., and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7.

### 8.509.12 SERVICES PROVIDED [Eff. 7/1/2012]

A. HCBS-CMHS services provided as an alternative to nursing facility placement include:

1. Adult Day Services
2. Alternative Care Services (which includes Homemaker and Personal Care services)
3. Consumer Directed Attendant Support Services (CDASS)
4. Electronic Monitoring
5. Home Delivered Meals
6. Home Modification
7. Homemaker Services
8. Life Skills Training (LST)
9. Non-Medical Transportation
10. Peer Mentorship
11. Personal Care
12. Respite Care
13. Transition Setup

B. Case management is not a service of the HCBS-CMHS program but shall be provided as an administrative activity through case management agencies.

C. HCBS-CMHS Clients are eligible for all other Medicaid State plan benefits.

**8.509.13 DEFINITIONS OF SERVICES**

A. Adult Day Services is defined at Section 8.491.

B. Alternative Care Services is defined at Section 8.495.1.

C. Consumer Directed Attendant Support Services (CDASS) is defined at Section 8.510.1.

D. Electronic Monitoring services is defined at Section 8.488.11.

E. Home Delivered Meals is defined at Section 8.553.1.

F. Home Modification is defined at Section 8.493.1.

G. Homemaker Services is defined at Section 8.490.1.

H. Life Skills Training (LST) is defined at Section 8.553.1.

I. Non-Medical Transportation is defined at Section 8.494.1.

J. Peer Mentorship is defined at Section 8.553.

K. Personal Care is defined at Section 8.500.94.B.12.

L. Respite is defined at Section 8.492.

M. Transition Setup is defined at Section 8.553.

**8.509.14 GENERAL DEFINITIONS**

A. Assessment shall be defined as a Client evaluation according to requirements at Section 8.509.31.B.

B. Case Management shall be defined as administrative functions performed by a case management agency according to requirements at Section 8.509.30.

C. Case Management Agency shall be defined as an agency that is certified and has a valid contract with the state to provide HCBS-CMHS case management.

D. Case Plan shall be defined as a systematized arrangement of information which includes the Client's needs; the HCBS-CMHS services and all other services which will be provided, including the funding source, frequency, amount and provider of each service; and the expected outcome or purpose of such services. This case plan shall be written on a state-prescribed case plan form.

E. Categorically Eligible, shall be defined in the HCBS-CMHS Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the Client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-CMHS as three hundred percent eligible persons, as defined at 8.509.14.S.

F. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

G. Uncertified Congregate Facility is a facility as defined in Section 8.509.14.G that is not certified as an Alternative Care Facility, which is defined at Section 8.495.1.

H. Continued Stay Review shall be defined as a re-assessment conducted as described at Section 8.402.60.

I. Cost Containment shall be defined at Section 8.485.50(I)

J. Department shall be defined as the State Agency designated as the Single State Medicaid Agency for Colorado, or another state agency operating under the authority of a memorandum of understanding with the Single State Medicaid Agency.

K. Deinstitutionalized shall be defined as waiver Clients who were receiving nursing facility services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-CMHS waiver. These include hospitalized Clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected the HCBS-CMHS waiver.

L. Diverted shall be define as HCBS-CMHS waiver recipients who were not deinstitutionalized, as defined at Section 8.485.50(K).

M. Home and Community-based Services for Community Mental Health Supports (HCBS-CMHS) shall be defined as services provided in a home or community-based setting to Clients who are eligible for Medicaid reimbursement for long-term care, who would require nursing facility care without the provision of HCBS-CMHS, and for whom HCBS-CMHS services can be provided at no more than the cost of nursing facility care.

N. Intake/Screening/Referral shall be as defined at Section 8.390.1(M) and as the initial contact with Clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long-term care Client assessment.

O. Level Of Care Screen shall be defined as an assessment conducted in accordance with Section 8.401.

P. Non-Diversion shall be defined as a Client who was certified by the URC as meeting the level of care screen and target group for the HCBS-CMHS program, but who did not receive HCBS-CMHS services for some other reason.

Q. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8.390-8.393 and 8.487 are met.

R. Reassessment shall be defined as a periodic revaluation according to the requirements at Section 8.509.32.C.

S. Three Hundred Percent (300%) Eligible persons shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level, and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for thirty (30) consecutive days.

**8.509.15 ELIGIBLE PERSONS**

A. HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

Clients shall meet the eligibility criteria as specified in 9 CCR 2503-5, and the Section 8.100.

2. Level of Care AND Target Group.

Clients who have been determined to meet the level of care AND target group criteria shall be certified by the Utilization Review Contractor (URC) as functionally eligible for HCBS-CMHS. The URC shall only certify HCBS-CMHS eligibility for those Clients:

a. Determined to meet the target group definition, defined as a person experiencing a severe and persistent mental health need that requires assistance with one or more Activities of Daily Living (ADL);

i. A person experiencing a severe and persistent mental health need is defined as someone who:

1) Is 18 years of age or older with a severe and persistent mental health need; and

2) Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM -5); and

a) Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and

b) Has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

ii. A severe and persistent mental health need does not include:

1) Intellectual or developmental disorders; or

2) Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.

b. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11-15; and

c. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.

3. Receiving Services

   a. Only Clients who receive HCBS-CMHS services, or who have agreed to accept HCBS-CMHS services as soon as all other eligibility criteria have been met, are eligible for the HCBS-CMHS program.

   b. Case management is not a service and shall not be used to satisfy this requirement.

   c. Desire or need for home health services or other Medicaid services that are not HCBS-CMHS services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.

   d. HCBS-CMHS Clients who have not received HCBS-CMHS services for thirty (30) days shall be discontinued from the program.

4. Institutional Status

   a. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-CMHS services while residing in such institutions.

   b. A Client who is already an HCBS-CMHS recipient and who enters a hospital may not receive HCBS-CMHS services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the Client from the HCBS-CMHS program.

   c. A Client who is already an HCBS-CMHS recipient and who enters a nursing facility may not receive HCBS-CMHS services while in the nursing facility;

      1) The case manager must terminate the Client from the HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ULTC-100.2 for the nursing facility placement, as verified by telephoning the URC.

      2) A Client receiving HCBS-CMHS services who enters a nursing facility for Respite Care as a service under the HCBS-CMHS program shall not be required to obtain a nursing facility ULTC-100.2, and shall be continued as an HCBS-CMHS Client in order to receive the HCBS-CMHS service of Respite Care in a nursing facility.

5. Cost-effectiveness

   Only Clients who can be safely served within cost containment, as defined at Section 8.509.14 (I), are eligible for the HCBS-CMHS program. The equivalent cost of nursing facility care is calculated by the State, according to Section 8.509.19.

**8.509.16 START DATE**

The start date of eligibility for HCBS-CMHS services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which HCBS-CMHS services can be reimbursed shall be the LATER of any of the following:

A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care This date is determined by the official URC-assigned start date on the ULTC 100.2 form.

C. Receiving Services This date shall be determined by the date on which the Client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept HCBS-CMHS services.

D. Institutional Status HCBS-CMHS eligibility cannot precede the date of discharge from the hospital or nursing facility.

**8.509.17 CLIENT PAYMENT OBLIGATION - POST ELIGIBILITY TREATMENT OF INCOME (PETI)**

When a Client has been determined eligible for Home and Community-based Services (HCBS) under the 300% income standard, according to Section 8.100, of Staff Manual Volume 8, the State may reduce Medicaid payment for Alternative Care Facility services according to the procedures at Section 8.509.31, E, of Staff Manual Volume 8.

**8.509.18 STATE PRIOR AUTHORIZATION OF SERVICES**

A. Upon receipt of the Prior Authorization Request (PAR), as described at Section 8.509.31(G), the state or its agent shall review the PAR to determine whether it is in compliance with all applicable regulations, and whether services requested are consistent with the Client's documented medical condition and functional capacity, and are reasonable in amount, frequency, and duration. Within ten (10) working days the State or its agent shall:

1. Approve the PAR and forward signed copies of the prior authorization form to the case management agency, when all requirements are met;

2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear, or incorrect; or if services requested are not adequately justified;

3. Disapprove the PAR when all requirements are not met Services shall be disapproved that are duplicative of other services that the Client is receiving or services for which the Client is receiving funds to purchase Services shall also be disapproved if all services, regardless of funding source, total more than twenty-four hours per day care.

B. When services are disapproved, in whole or in part the Department or its agent shall notify the case management agency. The case management agency shall notify the Client of the adverse action and the appeal rights on a state-prescribed form, according to Section 8.057, et seq.

C. Revisions received by the Department or its agent six (6) months or more after the end date shall always be disapproved.

D. Approval of the PAR by the Department or its agent shall authorize providers of services under the case plan to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the Client's financial eligibility for long-term care medical assistance (Medicaid) on the dates of service; and upon providers' use of correct billing procedures.

**8.509.19 STATE CALCULATION OF COST-CONTAINMENT AMOUNT**

A. The State shall annually compute the equivalent monthly cost of nursing facility care according to Section 8.485.100.

B. LIMITATIONS ON PAYMENT TO FAMILY

1. With the exception of Consumer Directed Attendant Support Service, in no case shall any person be reimbursed to provide HCBS-CMHS services to his or her spouse.

2. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-CMHS program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the Client by virtue of blood, marriage, adoption or common law.

3. 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.

4. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

   a. The maximum number of personal care units per annual certification for HCBS-CMHS shall be the equivalent of 444 hours. Family members must average at least 1.2164 hours of care per day (as indicated on the Client's care plan) in order to receive the maximum reimbursement.

   b. The maximum shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision and all other administrative costs.

   c. If the certification period for HCBS-CMHS is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the Client is receiving care by the average units per day for a full year (444/365=1.2164).

5. If two or more HCBS-CMHS Clients reside in the same household, family members may be reimbursed up to the maximum for each Client if the services are not duplicative and are appropriate to meet the Client's needs.

6. When HCBS-CMHS funds are utilized for reimbursement of personal care services provided by the Client's family, the home care allowance cannot be used to reimburse the family.

7. Services other than personal care or Consumer Directed Attendant Support Services shall not be reimbursed with the HCBS-CMHS funds when provided by the Client's family.

C. CLIENT RIGHTS

1. The case manager shall inform Clients eligible for HCBS-CMHS in writing, of their right to choose between HCBS-CMHS services and nursing facility care; and

2. The case manager shall offer Clients eligible for HCBS-CMHS, the free choice of any and all available and qualified providers of appropriate services.

**8.509.20 CASE MANAGEMENT AGENCIES**

A. The requirement at Section 8.390 et. seq. shall apply to the case management agencies performing the case management functions of the HCBS-CMHS program.

8.509.21 CERTIFICATION

A. Case management agencies shall be certified, monitored and periodically recertified as required in Section 8.394 et. seq.

B. Case management agencies must have provider agreements with the Department that are specific to the HCBS-CMHS program.

8.509.22 REIMBURSEMENT

Case management agencies shall be reimbursed for case management activities according to Section 8.392 et. seq.

**8.509.30 CASE MANAGEMENT FUNCTIONS**

8.509.31 NEW HCBS-CMHS CLIENTS

A. INTAKE/SCREENING/REFERRAL

1. Case management agency staff shall complete a State-prescribed Intake form in accordance with the Single Entry Point Intake Procedures at Section 8.393.2 for each potential HCBS-CMHS applicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the applicant for purposes of establishing a start date. Additionally, at intake, Clients shall be offered an opportunity to identify a third party to receive Client notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to Clients.

2. Case management agency staff shall verify the individual's current financial eligibility status or refer the Client to the county department of social services of the Client's county of residence for application. This verification shall include whether the applicant is in a category of assistance that includes financial eligibility for long-term care.

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long-term care Client assessment (ULTC-100.2), and shall explain the reasons for the decision on the Intake form. The Client shall be informed of the right to request an assessment if the Client disagrees with the case manager's decision.

4. If the case management agency staff has determined that a comprehensive uniform long-term care client assessment (ULTC-100.2) is needed, or if the Client requests an assessment, a case manager shall be assigned to schedule the assessment.

B. ASSESSMENT

1. The URC/SEP case manager shall complete the Uniform Long-term Care Client Assessment Instrument (ULTC 100.2) in accordance with Section 8.393.2, ASSESSMENT.

2. The URC/SEP case manager shall begin and complete the assessment within ten (10) days of notification of Client's need for assessment.

3. The URC/SEP case manager shall complete the following activities for a comprehensive client assessment:

   a. Obtain all required information from the Client's medical provider including information required for target group determination;

   b. Determine the Client's functional capacity during a face-to-face interview, preferably with the observation of the Client in his or her residential setting. Upon Department approval, the assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).;

   c. Determine the ability and appropriateness of the Client's caregiver, family, and other collateral, to provide the Client assistance in activities of daily living;

   d. Determine the Client's service needs, including the Client's need for services not provided under HCBS-CMHS

   e. If the Client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;

   f. Review service options based on the Client's needs, the potential funding sources, and the availability of resources;

   g. Explore the Client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;

   h. View and document the current Assisted Living Residence license, if the Client lives, or plans to live, in a congregate facility as defined at Section 8.509.14in order to assure compliance with the regulation at Section 5.509.11(B).

   i. Determine and document Client preferences in program selection;

   j. Complete documentation on the ULTC 100.2 form.

k. To de-institutionalize a Client who is in a nursing facility under payment by Medicaid, and with a current ULTC 100.2 already certified by the URC/SEP agency for the nursing facility level of ULTC 100.2 completion date is older than six (6) months, the URC/SEP case manager shall complete a new ULTC 100.2 and determine if the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-CMHS, the case manager must obtain a new ULTC 100.2 and the Client shall be treated as an applicant from the community rather than as a de-institutionalized Client.

l. It is the URC/SEP case manager's responsibility to assess the behaviors of the Client and assure that community placement is appropriate.

C. HCBS-CMHS DENIALS AND/OR DISCONTINUATIONS

1. If a Client is determined, at any point in the assessment process, to be ineligible for HCBS-CMHS according to any of the requirements at Section 8.509.15, the case manager shall refer the Client or the Client's designated representative to other appropriate services. Clients who are denied HCBS-CMHS services shall be notified of denials and appeal rights as follows:

a. Financial Eligibility

The income maintenance technician at the county department of social services shall notify the applicant of denial for reasons of financial eligibility and shall inform the applicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.

b. Level of Care AND Target Group

The URC shall notify the applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the applicant of appeal rights in accordance with Section 8.057. The case manager shall not make judgments as to eligibility regarding level of care or target group, and shall refer all applicants who request a URC review to the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.

c. Receiving Services

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determines that the applicant does not meet the HCBS-CMHS eligibility requirements at Section 8.509.15 and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

d. Institutional Status

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement at Section 8.509.15 and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

e. Cost-effectiveness

The case manager shall notify the applicant of denial, on State-prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement 8.509.15 and shall inform the applicant of appeal rights in accordance with Section 8.057, et.seq. The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-CMHS eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the Client's physician attesting to the Client's mental competency status, and all other available information which will support the determination that the Client is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the URC in regard to level of care and target group determination.

f. Waiver Cap

The case manager shall notify the applicant of denial, on a State-prescribed form, when the waiver cap limiting the number of Clients who may be served under the terms of the approved waiver has been reached.

D. SERVICE PLANNING

1. Service Planning shall be defined in accordance with case planning at Section 8.393.2 and shall include, but not be limited to, the following tasks:

a. The identification and documentation of service plan goals and Client choices;

b. The identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, finding source, and services needed but not available;

c. Documentation of the Client's choice of HCBS-CMHS services, nursing home placement, or other services, including a physical or digitally signed statement of choice from the Client;

d. Documentation that the Client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the Client understands his/her right to change providers;

e. The formalization of the service plan agreement on a State-prescribed service plan form, including appropriate physical or digital signatures;

f. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the Client regarding service provision;

g. Referral to community resources as needed and development of resources for individual Clients if a resource is not available within the Client's community;

h. The explanation of complaint procedures to the Client.

2. The case manager shall meet the Client's needs, with consideration of the Client's choices, using the most cost-effective methods available.

E. CALCULATION OF CLIENT PAYMENT (PETI)

1. The case manager shall calculate the Client payment (PETI) for 300% eligible HCBS-CMHS Clients according to the following procedures:

a. For 300% eligible HCBS-CMHS Clients who are not Alternative Care Facility Clients, the case manager shall allow an amount equal to the 300% standard as the Client maintenance allowance. No other deductions are necessary and no form is required to be completed.

b. For 300% eligible Clients who are Alternative Care Facility Clients, the case manager shall complete a State-prescribed form which calculates the Client payment according to the following procedures:

1) An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the Client's gross income to be used as the Client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid: and

2) For an individual with financial responsibility for only a spouse, an amount equal to the state Aid to the Needy Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the Client's gross income: or

3) For an individual with financial responsibility 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 who is either a full-time student of a part-time student as defined at Section 8.100.3.L.2.d.) shall be deducted from the Client's gross income; and

4) Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the Client's gross income as follows:

a) Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS: deductible or co-insurance charges: and

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

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

d) Medications, with the following limitations:

(1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the medication; 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) Medications which may be purchased with the Client’s Medical Identification Card shall not be allowed as deductions.

(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.

(5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

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

(1) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. 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 regular 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.

g) 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.

5) 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 Client directly to the facility; and

6) If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the Client's income, the remaining income shall be kept by the Client and may be used as additional personal needs or for any other use that the Client desires, except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services.

2. Case managers shall inform HCBS-CMHS Alternative Care Facility Clients of their Client payment obligation on a form prescribed by the state at the time of the first assessment visit by the end of each plan period; or within ten (10) working days whenever there is a significant change in the Client payment amount Significant change is defined as fifty dollars ($50) or more. Copies of Client payment forms shall be kept in the Client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request, according to Section 8.509.31.G, or if requested by the state for monitoring purposes.

F. COST CONTAINMENT

The case manager shall determine whether the person can be served at or under the cost containment criteria of Section 8.509.14(I) for long-term care services for an individual recipient by using a state-prescribed Prior Authorization Request (PAR) form to:

1. Determine the maximum authorized costs for all HCBS-CMHS services for the period of time covered by the case plan and compute the average cost per day by dividing by the number of days in we case plan period; and

2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:

a. Enter (in the designated space on the PAR form) the average monthly cost of nursing facility care; and

b. Subtract from that amount the Client's gross monthly income: and

c. Subtract from that amount the Client's Home Care Allowance grant amount, if any: and

d. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount which cannot be exceeded for the cost of HCBS services.

3. An individual Client whose service needs exceed the amount allowed under the Client's individual cost containment amount may choose to purchase additional services with personal income, but no Client shall be required to do so.

G. PRIOR AUTHORIZATION REQUESTS

1. The case manager shall complete and submit a prior authorization request (PAR) for all HCBS-CMHS services to the state or its agent in a timely manner in accordance with the STATE PRIOR AUTHORIZATION OF SERVICES in Section 8.485.90..

2. If a PAR includes a request for home modification services, the PAR shall also include all documentation listed at Section 8.493, HOME MODIFICATION.

3. If a PAR is for an Alternative Care Facility Client who is 300% eligible, the most recent state-prescribed Client Payment form shall be included in the PAR. All medical and remedial care requested as deductions on the Client Payment form must be listed on the long-terml Service Plan form.

4. The start date on the prior authorization request form shall never precede the start date of eligibility for HCBS-CMHS services, according to Section 8.509.16, START DATE.

5. The PAR shall not cover a period of time longer than the length of stay assigned by the URC.

6. A PAR does not have to be submitted for a non-diversion, as defined at 8.509.14(O).

7. If a PAR is returned to the case management agency for corrections, the corrected PAR must be returned to the State or its agent within thirty (30) calendar days after the case management agency receives the “Return to Provider” letter.

H. CASE MANAGEMENT AGENCY RESPONSIBILITY

1. The case management agency shall be financially responsible for any services which it authorized to be provided to the Client, or which continue to be rendered by a provider due to the case management agency's failure to timely notify the provider that the Client was no longer eligible for services, which did not receive approval by the state or its agent.

**8.509.32 ONGOING HCBS-CMHS CLIENTS**

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS Clients shall be in accordance with Section 8.393.2. In addition, the case manager shall:

a. Contact each Client quarterly, or more frequently, as determined by the Client’s assessed needs. Contact may be at the Client’s place of residence, by telephone, or other appropriate setting as determined by the Client’s needs.

b. Review the ULTC.100.2 and the Service Plan with the client every six (6) months on a face-to-face basis. 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 Client (e.g. natural disaster, pandemic, etc.).

2. The case manager shall refer the Client for mental health services taking into account Client choice. The case manager shall coordinate case management activities for those Clients who are receiving mental health services from the Behavioral Health Organizations (BHO).

3. On-going case management shall include, but not be limited to the following tasks:

a. Review of the Client's case plan and service agreements;

b. Contact with the Client concerning whether services are being delivered according to the plan; and the Client's satisfaction with services provided;

c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;

d. Contact with appropriate parties in the event any issues or complaints have been presented by the Client or others;

e. Conflict resolution and/or crisis intervention, as needed;

f. Informal assessment of changes in Client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;

g. Notification of appropriate enforcement agencies, as needed; and

h. Referral to community resources, and arrangement for non-HCBS-CMHS services, as needed.

4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or mis-utilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

B. REVISIONS

1. SERVICES ADDED TO THE SERVICE PLAN

a. Whenever a change in the service plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the state or its agent.

1) The revision PAR shall include the revised Long-term Care plan form and the revised Prior Authorization Request form.

2) The revised service plan form shall list the services being revised and shall state the reason for the revision. Services on the revised service plan form, plus all services on the original service plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.

3) The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.

b. If a revised PAR includes a new request for home modification services, the revised PAR shall also include all documentation listed at Section 8.493.

2. SERVICES DECREASED ON THE SERVICE PLAN

a. If services are decreased without the Client's agreement according to Section 8.057.5, the case manager shall notify the Client of the adverse action and of appeal rights, according to Section 8.057, et. seq.

C. REASSESSMENT

1. The case manager shall complete a reassessment of each HCBS-CMHS Client before the end of the length of stay assigned by the URC at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect HCBS-CMHS eligibility.

2. The case manager shall complete the reassessment, utilizing the Uniform Long-term Care Client Assessment Instrument (ULTC 100.2).

3. Reassessment shall include, but not be limited to, the following activities:

a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long-term care benefits;

b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;

c. Evaluate continuing need for the HCBS-CMHS program, and clearly document reasons for continuing HCBS; or terminate the Client's eligibility according to Section 8.509.32(E);

d. Ensure that all information needed from the medical provider for the URC level of care review is included on the ULTC 100.2 form;

e. Reassess the Client's functional status, according to the procedures in Section 8.509.31(B);

f. Review the case plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.509.31(D);

g. Refer the Client to community resources as needed;

h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31(G). For Clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ULTC 100.2. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the Client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Office of Administrative Courts to the Client; or (c) a copy of the notice of a scheduled court date.

Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be accepted as a substitute for the approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

D. TRANSFER PROCEDURES

1. When Clients move, cases shall be transferred according to the current statewide Mental Health Services Continuity of Care Policy.

2. INTERCOUNTY TRANSFERS shall be in accordance with Section 8.393.31.

3. INTERDISTRICT TRANSFERS shall be in accordance with Section 8.393.32.

E. TERMINATION

1. Clients shall be terminated from the HCBS-CMHS program whenever they no longer meet one or more of the eligibility requirements at Section 8.509.15. Clients shall also be terminated from the program if they die, move out of state or voluntarily withdraw from the program.

2. Clients who are terminated from HCBS-CMHS because they no longer meet one or more of the eligibility requirements at Section 8.509.15 shall be notified of the termination and their appeal rights as follows:

a. Financial Eligibility

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason.

b. Level of Care AND Target Group

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason.

c. Receiving Services

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason

d. Institutional Status

Procedures at Section 8.509.31(C) shall be followed for terminations for this reason. In the case of termination for extended hospitalization, the case manager shall send the termination notice on the thirtieth (30) day of hospitalization. The termination shall he effective at the end of the advance notice period. If the Client returns home before the end of the advance notice period, the termination shall be rescinded.

e. Cost-effectiveness

Procedures at Section 8.509.31(C) shall be followed for terminations for this reason.

3. When Clients are terminated from HCBS-CMHS for reasons not related to eligibility requirements at Section 8.509.31(C), the case manager shall follow the procedures below:

a. Death

Clients who die shall be terminated from the HCBS-CMHS program, effective upon the day after the date of death.

b. Moved out of State

Clients who move out of Colorado shall be terminated from the HCBS-CMHS program, effective upon the day after the date of the move. The case manager shall send the Client a state-prescribed Advisement Letter advising the Client that the case has been closed. Clients who leave the state on a temporary basis, with intent to return to Colorado, according to the Income Maintenance Staff Manual Section 1140.2, shall not be terminated from the HCBS-CMHS program unless one or more of the other eligibility criteria, as specified at Section 8.509.15 is no longer met.

c. Voluntary Withdrawal from the Program

Clients who voluntarily withdraw from the HCBS-CMHS program shall be terminated from the program, effective upon the day after the date on which the Client either requests in writing to withdraw from the program, or the date on which the Client enters a nursing facility. The case manager shall send the Client a state-prescribed Advisement Letter advising the Client that the case has been closed.

4. The case manager shall provide appropriate referrals to other community resources, as needed, upon termination.

5. The case manager shall immediately notify all providers on the case plan of any terminations.

6. If a case is terminated before an approved PAR has expired, the case manager shall submit, to the state or its agent, a copy of the current prior authorization request form, on which the end date is adjusted (and highlighted in some manner on the form); and the reason for termination shall be written on the form.

**8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS**

A. COMMUNICATION

In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the income maintenance technician of any and all changes in the Client's participation in HCBS-CMHS and shall provide the technician with copies of the first page of all URC-approved ULTC-100.2 forms.

2. The case manager shall inform all Alternative Care Facility Clients of their obligation to pay the full and current state-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

3. If the Client has an open service case file at the county department of social services, the case manager shall keep the Client's caseworker informed of the Client's status and shall participate in mutual staffing of the Client's case.

4. The case manager shall inform the Client's physician of any significant changes in the Client's condition or needs.

5. Within five (5) working days of receipt, from the State or it; agent, of the approved Prior Authorization Request form, the case manager shall provide copies to all the HCBS-CMHS providers in the case plan.

6. The case manager shall notify the URC, on a form prescribed by the state of the outcome of all non-diversions, as defined at Section 8.509.14.

7. The case manager shall report to the Colorado Department of Public Health and Environment any congregate facility which is not licensed.

8. The case management agency shall notify the state of any Client appeals which are initiated as a result of denials or terminations made by the case management agency.

B. CASE RECORDING/DOCUMENTATION

1. The case management agency shall maintain records on every individual for whom intake was conducted, including a copy of the intake form. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the case management agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.

2. The case record shall include:

   a. Identifying information, including the state identification (Medicaid) number, and

   b. All state-required forms; and

   c. Documentation of all case management activity required by these regulations.

3. Case management documentation shall meet all the following standards:

a. A separate case record shall be maintained for each Client receiving services in the Home and Community-based Services for Community Mental Health Supports Program.

b. Documentation shall be legible;

c. Entries shall be written at the time of the activity or shortly thereafter,

d. Entries shall be dated according to the date of the activity, including the year;

e. Entries shall be made in permanent ink or digital signature;

f. The Client shall be identified on every page;

g. The person making each entry shall be identified;

h. Entries shall be concise, but shall include all pertinent information;

i. All information regarding a Client shall be kept together for easy access and review by case managers, supervisors, program monitors and auditors;

j. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact, or is a judgment or conclusion on the part of anyone;

k. All persons and agencies referenced in the documentation shall be identified by name and by relationship to the Client;

l. All forms prescribed by the State shall be filled out by the case manager to be complete, correct and accurate.

m. If the individual is unable to sign a form requiring his/her signature because of a medical condition, a digital signature or any mark the individual is capable of making will 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 guardian or other authorized representative will be accepted.

4. All records shall be kept for the period of time specified in the case management agency contract, and shall be made available to the state as specified in the contract.

**8.509.40 HCBS-CMHS PROVIDERS**

A. Any provider agency with a valid contract to provide HCBS-EBD services, according to Section 8.487, shall be deemed certified to provide the same services to HCBS-CMHS Clients.

## 8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

### 8.510.1 DEFINITIONS

A. Adaptive Equipment means one or more devices used to assist with completing activities of daily living.

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

C. Assessment means a comprehensive evaluation with the Client seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the Client's medical provider to determine the Client's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department's prescribed tool to complete assessments.

D. Attendant means the individual who meets qualifications in 8.510.8 who provides CDASS as described in 8.510.3 and is hired by the Client or Authorized Representative through the contracted FMS vendor.

E. Attendant Support Management Plan (ASMP) means the documented plan described in 8.510.5, detailing management of Attendant support needs through CDASS.

F. Authorized Representative (AR) means an individual designated by the Client or the Client's legal guardian, if applicable, who has the judgment and ability to direct CDASS on a Client's behalf and meets the qualifications contained in 8.510.6 and 8.510.7.

G. Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6-106, C.R.S., and has a current provider participation agreement with the Department.

H. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual Client's functional eligibility for one or more Home and Community-based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the Client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and periodic reassessment of Client needs.

I. Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that empowers Clients 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.

J. CDASS Certification Period Allocation means the funds determined by the Case Manager and made available by the Department for Attendant services for the date span the Client is approved to receive CDASS within the annual certification period.

K. CDASS Task Worksheet: A tool used by a Case Manager to indicate the number of hours of assistance a Client needs for each covered CDASS personal care services, homemaker services, and health maintenance activities.

L. CDASS Training means the required CDASS training and comprehensive assessment provided by the Training and Operations Vendor to a Client or Authorized Representative.

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

N. 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.

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

P. Financial Eligibility means the Health First Colorado financial eligibility criteria based on Client income and resources.

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

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

S. Functional Eligibility means the physical and cognitive functioning criteria a Client must meet to qualify for a Medicaid waiver program, as determined by the Department's functional eligibility assessment tool.

T. Home and Community-based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to Clients in community settings. These services are designed to help older persons and persons with disabilities to live in the community.

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

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

W. Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the Client.

X. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web site, Client account statements, Case Manager contact, or FMS vendor contact.

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

Z. Training and Operations Vendor means the organization contracted by the Department to provide training and customer service for self-directed service delivery options to Clients, Authorized Representatives, and Case Managers.

**8.510.2 ELIGIBILITY**

8.510.2.A. To be eligible for the CDASS delivery option, the Client shall meet the following eligibility criteria:

1. Choose the CDASS delivery option.

2. Meet HCBS waiver functional and financial eligibility requirements.

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

4. Document a pattern of stable Client health indicating appropriateness for community-based services and a predictable pattern of CDASS Attendant support.

5. Provide a statement, at an interval determined by the Department, from the Client's primary care physician, physician assistant, or advanced practice nurse, attesting to the Client's ability to direct their care with sound judgment or a required AR with the ability to direct the care on the Client's behalf.

6. Complete all aspects of the ASMP and training and demonstrate the ability to direct care or have care directed by an AR.

    a. Client training obligations

        i. Clients and ARs who have received training through the Training and Operations Vendor in the past two years and have utilized CDASS in the previous six months may receive a modified training to restart CDASS following an episode of closure. The Case Manager will review the allocation and attendant management for the Client's previous service utilization and consult with the Department to determine whether full retraining is required, or an abbreviated training based on history of managing allocation and services is needed.

        ii. A Client who was terminated from CDASS due to a Medicaid financial eligibility denial that has been resolved may resume CDASS without attending training if they had received CDASS in the previous six months.

**8.510.3 COVERED SERVICES**

8.510.3.A. Covered services shall be for the benefit of only the Client and not for the benefit of other persons.

8.510.3.B. Services include:

1. Homemaker: General household activities provided by an Attendant in a Client's home to maintain a healthy and safe environment for the Client. Homemaker activities shall be provided only in the primary living space of the Client and multiple Attendants may not be reimbursed for duplicating homemaker tasks. Tasks may include the following activities or teaching the following activities:

a. Housekeeping, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas;

b. Meal preparation;

c. Dishwashing;

d. Bed making;

e. Laundry;

f. Shopping for necessary items to meet basic household needs.

2. Personal Care: Services furnished to an eligible Client in the community or in the Client's home to meet the Client's physical, maintenance, and supportive needs. Personal care tasks may include:

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 from or to the Client's face;

c. Preventive 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 Client to and from the bathroom;

ii) Assistance with bed pans, urinals, and commodes;

iii) Changing incontinence clothing or pads;

iv) Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v) Emptying ostomy bags;

vi) Perineal care.

e. Personal hygiene:

i) Bathing, including washing and shampooing;

ii) Grooming;

iii) Shaving with an electric or safety razor;

iv) Combing and styling hair;

v) Filing and soaking nails;

vi) Basic oral hygiene and denture care.

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 Client is able to assist or direct.

g. Transferring a Client when the Client 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 Client and Attendant are fully trained in the use of the equipment and the Client can direct and assist with the transfer.

h. Mobility assistance when the Client has the ability to reliably balance and bear weight or when the Client is independent with an assistive device.

i. Positioning when the Client is able to verbally or non-verbally identify when their position needs to be changed, including simple alignment in a bed, wheelchair, or other furniture.

j. Medication Reminders when the medications have been preselected by the Client, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders and:

i) Medication minders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;

ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the Client and opening the appropriately marked medication minder if the Client is unable to do so independently.

k. Cleaning and basic maintenance of durable medical equipment.

l. Protective oversight when the Client requires supervision to prevent or mitigate disability-related behaviors that may result in imminent harm to people or property.

m. Accompanying includes going with the Client, as indicated in the care plan, to medical appointments and errands, such as banking and household shopping. Accompanying the Client to provide one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands-on assistance when tasks cannot be completed without the support of the Attendant.

3. Health Maintenance Activities: Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible Client in the community or in the Client's home, which are necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out. 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 Client 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.

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

c. 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 Client is unable to participate in the task;

iv) Oral suctioning is required;

v) There is decreased oral sensitivity or hypersensitivity;

vi) Client is at risk for choking and aspiration.

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

i) The Client is unable to assist or direct care;

ii) Assistance with the application of prescribed anti-embolic or pressure stockings is required;

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

e. Feeding is considered a health maintenance task when the Client 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 Client is on a prescribed modified texture diet;

iii) The Client has a physiological or neurogenic chewing or swallowing problem;

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

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

f. Exercise prescribed by a Licensed Medical Professional, including passive range of motion.

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

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

ii) The Client 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.

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

i) The Client 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.

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

i) The Client 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.

j. 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.

k. 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.

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

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

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

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

i) The Client is unable to assist or direct care;

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

iii) The Client has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional

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

i) The Client is unable to assist or direct care, or

ii) The Client is unable to complete task independently

4. Services that may be directed by the Client or their selected AR under the Home and Community-based Supported Living Services (HCBS-SLS) waiver are as follows:

a. Homemaker services, as defined at Section 8.500.94.

b. Personal care services, as defined at Section 8.500.94.

c. Health maintenance activities as defined at Section 8.500.94.

**8.510.4 EXCLUDED SERVICES**

8.510.4.A. CDASS Attendants are not authorized to perform services and payment is prohibited:

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

2. Following the death of Client;

3. That are duplicative or overlapping. The Attendant cannot be reimbursed to perform tasks at the time a Client is concurrently receiving a waiver service in which the provider is required to perform the tasks in conjunction with the service being rendered;

Companionship is not a covered CDASS service.

**8.510.5 ATTENDANT SUPPORT MANAGEMENT PLAN**

8.510.5.A. The Client/AR shall develop a written ASMP after completion of training but prior to the start date of services, which shall be reviewed by the Training and Operations Vendor and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date to the FMS. The ASMP is required following initial training and retraining and shall be modified when there is a change in the Client's needs. The plan shall describe the Client's:

1. Needed Attendant support;

2. Plans for locating and hiring Attendants;

3. Plans for handling emergencies;

4. Assurances and plans regarding direction of CDASS Services, as described at 8.510.3 and 8.510.6, if applicable.

5. Plans for budget management within the Client's Allocation.

6. Designation of an AR, if applicable.

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

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

**8.510.6 CLIENT/AR RESPONSIBILITES**

8.510.6.A. Client/AR responsibilities for CDASS Management:

1. Complete training provided by the Training and Operations Vendor. Clients who cannot complete trainings shall designate an AR.

2. Develop an ASMP at initial enrollment and at time of an Allocation change based on the Client's needs.

3. Determine wages for each Attendant not to exceed the rate established by the Department. 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 at the location where the service is provided.

4. Determine the required qualifications for Attendants.

5. Recruit, hire and manage Attendants.

6. Complete employment reference checks on Attendants.

7. Train Attendants to meet the Client's needs. When necessary to meet the goals of the ASMP, the Client/AR shall verify that each Attendant has been or will be trained in all necessary health maintenance activities prior to performance by the Attendant.

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

9. Operate as the Attendant's legal employer of record.

10. Complete necessary employment-related functions through the FMS vendor, including hiring and termination of Attendants and employer-related paperwork necessary to obtain an employer tax ID.

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

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

13. Explain the role of the FMS vendor to the Attendant.

14. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation. Services that exceed the Client's monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the Client or AR for reimbursement through the FMS vendor.

15. Authorize Attendant to perform services allowed through CDASS.

16. Ensure all Attendants required to utilize EVV are trained and complete EVV for services rendered. Timesheets shall be reviewed and reflect time worked that all required data points are captured to maintain compliance with 8.001.

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

18. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement.

19. Authorize the FMS vendor to make any changes in the Attendant wages.

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

21. Completing and managing all paperwork and maintaining employment records.

21. Select an FMS vendor upon enrollment into CDASS.

8.510.6.B. Client/AR responsibilities for Verification:

1. Sign and return a responsibilities acknowledgement form for activities listed in 8.510.6 to the Case Manager.

8.510.6.C. Clients utilizing CDASS have the following rights:

1. Right to receive training on managing CDASS.

2. Right to receive program materials in accessible format.

3. Right to receive advance Notification of changes to CDASS.

4. Right to participate in Department-sponsored opportunities for input.

5. Clients using CDASS have the right to transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.

6. A Client/AR may request a reassessment if the Client's level of service needs have changed.

7. A Client/AR may revise the ASMP at any time with Case Manager approval.

**8.510.7 AUTHORIZED REPRESENTATIVES (AR)**

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

1. Is least eighteen years of age;

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

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

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

8.510.7.B. CDASS Clients who require an AR may not serve as an AR for another CDASS Client.

8.510.7.C. An AR shall not receive reimbursement for CDASS AR services and shall not be reimbursed as an Attendant for the Client they represent.

8.510.7.D. An AR must comply with all requirements contained in 8.510.6.

**8.510.8 ATTENDANTS**

8.510.8.A. Attendants shall be at least 16 years of age and demonstrate competency in caring for the Client to the satisfaction of the Client/AR.

1. 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).

8.510.8.B. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more Clients collectively.

8.510.8.C. An AR shall not be employed as an Attendant for the same Client for whom they are an AR.

8.510.8.D. Attendants must be able to perform the tasks on the ASMP they are being reimbursed for and the Client must have adequate Attendants to assure compliance with all tasks on the ASMP.

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

8.510.8.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.

8.510.8.G. Attendants shall not have had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

8.510.8.H. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the Client/AR not to exceed the amount established by the Department. The FMS vendor shall make all payments from the Client's Allocation under the direction of the Client/AR within the limits established by the Department.

8.510.8.I. Attendants are not eligible for hire if their background check identifies a conviction of a crime that the Department has identified as a barrier crime that can create a health and safety risk to the Client. A list of barrier crimes is available through the Training and Operations Vendor and FMS vendors.

8.510.8.J. Attendants may not participate in training provided by the Training and Operations Vendor. Clients 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.

**8.510.9 FINANCIAL MANAGEMENT SERVICES (FMS)**

8.510.9.A. FMS vendors shall be responsible for the following tasks:

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

2. 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.

3. Distribute paychecks in accordance with agreements made with Client/AR and timelines established by the Colorado Department of Labor and Employment.

4. Submit authorized claims for CDASS provided to an eligible Client.

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

6. Track and report utilization of Client allocations.

7. Comply with Department regulations and the FMS vendor contract with the Department.

8.510.9.B. In addition to the requirements set forth at 8.510.9.A, the FMS vendor operating under the F/EA model shall be responsible for obtaining designation as a Fiscal/Employer Agent in accordance with Section 3504 of the Internal Revenue Code (2021). 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.

**8.510.10 SELECTION OF FMS VENDORS**

8.510.10.A. The Client/AR shall select an FMS vendor at the time of enrollment into CDASS from the vendors contracted with the Department.

8.510.10.B The Client/AR may select a new FMS vendor during the designated open enrollment periods. The Client/AR shall remain with the selected FMS vendor until the transition to the new FMS vendor is completed.

**8.510.11 START OF SERVICES**

8.510.11.A. The CDASS start date shall not occur until all of the requirements contained in 8.510.2, 8.510.5, 8.510.6 and 8.510.8 have been met.

8.510.11.B. The Case Manager shall approve the ASMP, establish a service period, submit a PAR and receive a PAR approval before a Client is given a start date and can begin CDASS.

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

8.510.11.D. The FMS vendor will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS vendor provides the Client/AR with employee numbers and confirms Attendants' employment status.

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

**8.510.12 SERVICE SUBSTITUTION**

8.510.12.A. Once a start date has been established for CDASS, the Case Manager shall establish an end date and discontinue the Client 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.

8.510.12.B. Case Managers shall not authorize 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 Client.

8.510.12.C. Clients may receive up to sixty days of Medicaid Acute Home Health services directly following acute episodes as defined by 8.523.11.K.1. CDASS service plans shall be modified to ensure no duplication of services.

8.510.12.D. Clients may receive Hospice services in conjunction with CDASS services. CDASS service plans shall be modified to ensure no duplication of services.

**8.510.13 FAILURE TO MEET CLIENT/AR RESPONSIBILITIES**

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

1. Mandatory re-training conducted by the contracted Training and Operations Vendor.

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

8.510.13.B. Actions requiring retraining, or appointment or change of an AR include any of the following:

1. The Client/AR does not comply with CDASS program requirements including service exclusions.

2. The Client/AR demonstrates an inability to manage Attendant support.

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

4. The Client/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.

5. The Client/AR exhibits Inappropriate Behavior as defined at 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor, or the FMS vendor.

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

**8.510.14 IMMEDIATE INVOLUNTARY TERMINATION**

8.510.14.A. Clients may be involuntarily terminated immediately from CDASS for the following reasons:

1. A Client no longer meets program criteria due to deterioration in physical or cognitive health AND the Client refuses to designate an AR to direct services.

2. The Client/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 Client/AR to resolve the overspending have failed.

3. The Client/AR exhibits Inappropriate Behavior as defined at 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor or the FMS vendor, and the Department has determined that the Training and Operations Vendor has made attempts to assist the Client/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

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

5. Intentional submission of fraudulent CDASS documents or information to Case Managers, the Training and Operations Vendor, the Department, or the FMS vendor.

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

7. Client/AR fails to complete retraining, appoint an AR, or remediate CDASS management per 8.510.13.A.

8. Client/AR demonstrates a consistent pattern of non-compliance with EVV requirements determined by the EVV CDASS protocol.

    a. Members experiencing FMS EVV systems issues must notify the FMS Vendor and/or Department of the issue within 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.

**8.510.15 ENDING THE CDASS DELIVERY OPTION**

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

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

1. Complete the Notice Services Status (LTC-803) and provide the Client or AR with the reasons for termination, information about the Client's rights to fair hearing, and appeal procedures. Once notice has been given for termination, the Client or AR may contact the Case Manager for assistance in obtaining other home care services or additional benefits, if needed.

2. 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 Client. The Case Manager shall notify the FMS vendor of the date on which the Client is being terminated from CDASS.

8.510.15.C. Clients who are involuntarily terminated pursuant to 8.510.14.A 2., 8.510.14.A.4., 8.510.14.A.5, 8.510.14.A.6., and 8.510.14.A.7. may not be re-enrolled in CDASS as a service delivery option.

8.510.15.D. Clients who are involuntary terminated pursuant to 8.510.14.A.1. are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at 8.510.2.A.5. The Client or AR must have successfully completed CDASS training prior to enrollment in CDASS.

8.510.15.E. Clients who are involuntary terminated pursuant to 8.510.14.A.3 are eligible for enrollment in CDASS with the appointment of an AR. The Client must meet all CDASS eligibility requirements with the AR completing CDASS training prior to enrollment in CDASS.

8.510.15.F. Clients who are involuntarily terminated pursuant to 8.510.14.A.8 are eligible for enrollment in CDASS 365 days from the date of termination. The Client must meet all eligibility requirements and complete CDASS training prior to enrollment in CDASS.

**8.510.16 CASE MANAGEMENT FUNCTIONS**

8.510.16.A. The Case Manager shall review and approve the ASMP completed by the Client/AR. The Case Manager shall notify the Client/AR of ASMP approval and establish a service period and Allocation.

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

8.510.16.C. The Case Manager shall calculate the Allocation for each Client who chooses CDASS as follows:

1. 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 Client's Allocation.

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

3. Allocations that exceed care in an institutional setting cannot be authorized by the Case Manager without Department approval. The Case Manager will follow the Department's over-cost containment process and receive authorization prior to authorizing a start date for Attendant services.

8.510.16.D. Prior to training or when an Allocation changes, the Case Manager shall provide written Notification of the Allocation to the Client and the AR, if applicable.

8.510.16.E. A Client or AR who believes the Client 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.

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

   a. The Case Manager shall provide notice of the Allocation change to the Client/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.

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

c. The Client/AR shall amend the ASMP and submit it to the Case Manager.

2. The Training and Operations Vendor 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.

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

8.510.16.F. In approving an increase in the Client's Allocation, the Case Manager shall consider all of the following:

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

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

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

8.510.16.G. In reducing a Client's Allocation, the Case Manager shall consider:

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

2. Inaccuracies or misrepresentation in the Client's previously reported condition or need for service.

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

8.510.16.H. 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 Client's CDASS start date.

8.510.16.I. For effective coordination, monitoring and evaluation of Clients receiving CDASS, the Case Manager shall:

1. Contact the CDASS Client/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 Clients/ARs to the FMS vendor for assistance with payroll and to the Training and Operations Vendor for training needs, budgeting, and supports.

2. Contact the Client/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.

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

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

5. Utilize Department overspending protocol when needed to assist CDASS Client/AR.

6. Follow protocols established by the Department for case management activities.

8.510.16.J. Reassessment: The Case Manager will follow in-person and phone contact requirements based on the Client'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 Client's ability to direct care.

8.510.16.K. Case Managers shall participate in training and consulting opportunities with the Department's contracted Training and Operations Vendor.

**8.510.17 ATTENDANT REIMBURSEMENT**

8.510.17.A. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the Client/AR hiring the Attendant. The FMS vendor shall make all payments from the Client's Allocation under the direction of the Client/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified in the ASMP.

8.510.17.B. Attendant timesheets that exceed the Client's monthly CDASS Allocation by 30% or more are not allowed and cannot be authorized by the Client or AR for reimbursement through the FMS vendor.

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

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

**8.510.18 REIMBURSEMENT TO FAMILY MEMBERS**

8.510.18.A. Family Members/legal guardians may be employed by the Client/AR to provide CDASS, subject to the conditions below.

8.510.18.B. The family member or legal guardian shall be employed by the Client/AR and be supervised by the Client/AR.

8.510.18.C. 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:

1. 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.

2. 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 of that the Family Member has a higher level of skill.

3. A member of the Client'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 Client and avoid institutionalization. Extraordinary care shall be documented on the service plan.

8.510.18.D. A Client/AR who chooses a Family Member as a care provider, shall document the choice on the ASMP.

## 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). For the purposes of this rule, the base wage shall be $15.00 effective January 1, 2022.

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. Effective January 1, 2022, the Department will increase reimbursement rates for select Home and Community-Based Services. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher. Services requiring Direct Care Workers to be paid at least the base wage are as follows:

1. Adult Day Services

2. Alternative Care Facility (ACF)

3. Community Connector

4. Consumer Directed Attendant Support Services (CDASS)

5. Group Residential Support Services (GRSS)

6. Homemaker

7. Homemaker Enhanced

8. In-Home Support Services (IHSS)

9. Individual Residential Support Services (IRSS)

10. Job Coaching

11. Job Development

12. Mentorship

13. Personal Care

14. Prevocational Services

15. Respite

16. Specialized Habilitation

17. Supported Community Connections

18. 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 effective January 1, 2022 by the percent of the Department's January 1, 2022 reimbursement rate increase.

D. Effective July 1, 2022, the Department will increase reimbursement rates for Foster Care Home, Host Home, and Group Home Habilitation service in the Home and Community Based Services-Children's Habilitation Residential Program (CHRP) waiver. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher.

1. 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 effective July 1, 2022 by the percent of the Department's July 1, 2022 reimbursement rate increase.

**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 who are affected by the base wage requirement each fiscal year up to and including Fiscal Year 2023-2024.

1. Provider shall utilize the Department provided letter.

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. On or before June 30, 2022 and June 30, 2023, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

1. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after January 1, 2022.

d. Direct Care Workers' hourly base wage as of November 1, 2021 and current hourly base wage.

e. Current service(s) provided by each employee.

2. IRSS Providers and/or Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after January 1, 2022.

d. Direct Care Workers' per diem wage as of December 1, 2021 and per diem wage as of January 1, 2022.

3. CDASS Authorized Representatives/Employers of Record are exempt from attestation requirements.

E. For CHRP Habilitation Foster Care Home, Host Home, and Group providers, on or before June 30, 2023, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

1. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after July 1, 2022.

d. Direct Care Workers' hourly base wage as of May 1, 2022 and current hourly base wage.

e. Current service(s) provided by each employee.

2. Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after July 1, 2022.

d. Direct Care Workers' per diem wage as of June 1, 2022 and per diem wage as of July 1, 2022.

F. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the listed services within Section 8.511 received at a minimum the base wage or a per diem wage increase.

G. 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

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 services listed in Section 8.511.2 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 provide adequate documents and timely responses may result in the Provider being required to submit a plan of correction and/or recoupment of funds.

D. If a plan of correction is requested by the Department, the Provider shall have forty-five (45) business days from the date of the request to respond. 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 HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH BRAIN INJURY (HCBS-BI)

### 8.515.1 LEGAL BASIS

The Home and Community-based Services for Persons with Brain Injury (HCBS-BI) program is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. Section 1396a(a)(10)(B) (2018). This waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. Section 1396n (2018). This regulation is adopted pursuant to the authority in Section 25.5-1-303, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Sections 24-4-101 et seq., C.R.S. and the Home and Community-based Services for Persons with Brain Injury Act, Sections 25.5-6-701 et seq., C.R.S.

### 8.515.2 HCBS-BI WAIVER SERVICES

8.515.2.A SERVICES PROVIDED

1. Adult Day Services
2. Behavioral Programming and Education
3. Consumer Directed Attendant Support Services (CDASS)
4. Counseling Services
5. Day Treatment
6. Electronic Monitoring Services
7. Home Delivered Meals
8. Home Modification
9. Independent Living Skills Training (ILST)
10. Non-Medical Transportation Services
11. Peer Mentorship
12. Personal Care
13. Respite Care
14. Specialized Medical Equipment and Supplies
15. Substance Abuse Counseling
16. Supported Living
17. Transition Setup
18. Transitional Living Program

8.515.2.B DEFINITIONS OF SERVICES

1. Adult Day Services means services as defined at Section 8.491.

2. Behavioral Programming and Education means services as defined at Section 8.516.40.

3. Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.

4. Counseling Services means services as defined at Section 8.516.50.

5. Day Treatment means services as defined at Section 8.515.80.

6. Electronic Monitoring Services means services as defined at Section 8.488.

7. Home Delivered Meals means services as defined at Section 8.553.

8. Home Modification means services as defined at Section 8.493.

9. Independent Living Skills Training (ILST) means services as defined at Section 8.516.10.

10. Non-Medical Transportation Services means services as defined at Section 8.494.

11. Peer Mentorship means services as defined at Section 8.553.

12. Personal Care means services as defined at Section 8.489.

13. Respite Care means services as defined at Section 8.516.70.

14. Specialized Medical Equipment and Supplies means services as defined at Section 8.515.50.

15. Substance Abuse Counseling means services as defined at Section 8.516.60.

16. Supported Living means services delivered by a community-based residential program that has been certified by the Department to provide the services defined at Section 25.5-6-703(8), C.R.S.

17. Transition Setup means services defined at Section 8.553.

18. Transitional Living Program means services as defined at Section 8.516.30.

**8.515.3 GENERAL DEFINITIONS**

Brain Injury means an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Nonpsychotic mental disorders due to brain damage; or

2. Anoxic brain damage; or

3. Compression of the brain; or

4. Toxic encephalopathy; or

5. Subarachnoid and/or intracerebral hemorrhage; or

6. Occlusion and stenosis of precerebral arteries; or

7. Acute, but ill-defined cerebrovascular disease; or

8. Other and ill-defined cerebrovascular disease; or

9. Late effects of cerebrovascular disease; or

10. Fracture of the skull or face; or

11. Concussion resulting in an ongoing need for assistance with activities of daily living; or

12. Cerebral laceration and contusion; or

13. Subarachnoid, subdural, and extradural hemorrhage, following injury; or

14. Other unspecified intracranial hemorrhage following injury; or

15. Intracranial injury; or

16. Late effects of musculoskeletal and connective tissue injuries; or

17. Late effects of injuries to the nervous system; or

18. Unspecified injuries to the head resulting in ongoing need for assistance with activities of daily living.

Case Management Agency means the agency designated by the Department to provide the Single Entry Point Functions detailed at Section 8.393.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Service Plan means the plan developed by the case manager in coordination with the HCBS-BI Client and/or the legal guardian to identify and document the HCBS-BI services, other Medicaid services, and any other non-Medicaid services or supports that the HCBS-BI Client requires in order to live successfully in the community.

**8.515.4 SCOPE AND PURPOSE**

The HCBS-BI program provides those services listed at Section 8.515.2.A to eligible individuals with brain injury that require long-term supports and services in order to remain in a community-based setting.

**8.515.5 ELIGIBLE PERSONS**

HCBS-BI program enrollment and services shall be offered only to individuals determined by the Department or its agent to have met all eligibility requirements in this Section 8.515.5.

8.515.5.A LEVEL OF CARE

Eligible individuals shall be determined by the Department or its agent to require one of the following levels of care:

1. Hospital Level of Care as evidenced by:

    a. The individual shall have been:

        i. Referred to the Case Management Agency while receiving inpatient care in an acute care or rehabilitation hospital for the treatment of the individual's brain injury; or

        ii. Determined by the Department or its agent to have a significant functional impairment as evidenced by a comprehensive functional assessment using the Uniform Long-term Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15; and

    c. The individual shall require goal-oriented therapy with medical management by a physician; and

    d. The individual cannot be therapeutically managed in a community-based setting without significant supervision and structure, specialized therapy, and support services.

2. Nursing Facility Level of Care as evidenced by all the following:

    a. The individual shall have been determined by the Department or its agent to have a significant functional impairment as evidenced by a comprehensive functional assessment using the Uniform Long-term Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15;

    b. The individual shall require long-term support services at a level comparable to those services typically provided in a nursing facility.

8.515.5.B TARGET GROUP

Eligible individuals shall be determined by the Department or its agent to meet all the following target group criteria:

1. The individual shall have a diagnosis of Brain Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) and the ULTC 100.2 assessment tool.

2. Age Limit

    a. Individuals enrolled in the Brain Injury waiver shall be aged 16 years and older and shall have sustained the brain injury prior to the age of 65.

8.515.5.C FINANCIAL ELIGIBILITY

Individuals must meet the financial requirements for long-term care medical assistance eligibility specified at Section 8.100.7.

8.515.5.D NEED FOR HCBS-BI SERVICES

1. Only Clients that currently receive HCBS-BI services, or that have agreed to accept HCBS-BI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-BI program.

    a. Case management is provided as an administrative function, not an HCBS-BI service, and shall not be used to satisfy this requirement.

    b. The desire or need for any Medicaid services other than HCBS-BI services, as listed at Section 8.515.1, shall not satisfy this eligibility requirement.

2. Clients that have not received an HCBS-BI service for a period greater than 30 consecutive days shall be discontinued from the program.

8.515.5.E EXCLUSIONS FROM ELIGIBILITY

1. Individuals who are residents of nursing facilities, hospitals, or other institutional settings are not eligible to receive HCBS-BI services.

2. HCBS-BI Clients that enter a nursing facility or hospital may not receive HCBS-BI services while admitted to the nursing facility or hospital.

    a. HCBS-BI Clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-BI program.

    b. HCBS-BI Clients entering a nursing facility for Respite Care as an HCBS-BI service shall not be discontinued from the HCBS-BI program.

8.515.5.F COST CONTAINMENT AND SERVICE ADEQUACY OF SERVICES

1. The Client shall not be eligible for the HCBS-BI program if the case manager determines any of the following during the initial assessment and service planning process:

    a. The Client’s needs cannot be met within the Individual Cost Containment Amount.

    b. The Client’s needs are more extensive than HCBS-BI program services are able to support and/or that the Client’s health and safety cannot be assured in a community setting.

2. The Client shall not be eligible for the HCBS-BI program at reassessment if the case manager determines the Client’s needs are more extensive than HCBS-BI program services are able to support and/or that the Client’s health and safety cannot be assured in a community setting.

3. If the case manager determines that the Client’s needs are more extensive than the HCBS-BI services are able to support and/or that the Client’s health and safety cannot be assured in a community setting, the case manager must document:

    a. The results of an Adult Protective Services assessment;

    b. A statement from the Client’s physician attesting to the Client’s mental competency status; and

c. Any other documentation necessary to support the determination

4. The Client may be eligible for the HCBS-BI program at reassessment if the case manager determines that HCBS-BI program services are able to support the Client's needs and the Client's health and safety can be assured in a community setting.

a. If the case manager expects that the services required to support the Client's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the Client's request for services is appropriate and justifiable based on the Client's condition.

i. The Client may request of the case manager that existing services remain intact during this review process.

ii. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the Client with:

1) The Client's appeal rights pursuant to Section 8.057; and

2) Alternative options to meet the Client's needs that may include, but are not limited to, nursing facility placement.

**8.515.6 START DATE FOR SERVICES**

8.515.6.A. The start date of eligibility for HCBS-BI services shall not precede the date that all of the requirements in Section 8.515.5, have been met. The first date for which HCBS-BI services may be reimbursed shall be the later the following:

1. The date at which financial eligibility is effective.

2. The date at which the Department or its agent has determined that the Client has met all eligibility requirements at Section 8.515.5.

3. The date at which the Client agrees to accept services and signs all necessary intake and service planning forms.

4. The date of discharge from an institutional setting.

**8.515.7 PRIOR AUTHORIZATION OF SERVICES**

8.515.7.A. All HCBS-BI services must be prior authorized by the Department or its agent.

8.515.7.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.515.7.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the Client's documented medical condition and functional capacity;

2. Reasonable in amount, scope, frequency, and duration;

3. Not duplicative of the other services or supports included in the Client's Service Plan;

4. Not for services for which the Client is receiving funds to purchase; and

5. Do not total more than 24 hours per day of care.

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

8.515.7.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-BI services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR.

1. Payment for HCBS-BI services is also conditional upon:

a. The Client's eligibility for HCBS-BI services;

b. The provider's certification status; and

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

8.515.7.F. The prior authorization of services does not constitute an entitlement to those services. All services provided and reimbursed must be delivered in accordance with regulation and be necessary to meet the Client's needs.

8.515.7.G. Services requested on the PAR shall be supported by information on the Service Plan and the ULTC-100.2 assessment.

8.515.7.H. The PAR start date shall not precede the start date of HCBS-BI eligibility in accordance with Section 8.515.6.

8.515.7.I. The PAR end date shall not exceed the end date of the HCBS-BI eligibility certification period.

**8.515.8 WAITING LIST**

8.515.7.A. Persons determined eligible for HCBS-BI services that cannot be served within the capacity limits of the HCBS-BI waiver shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the person's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.515.5 were determined to have been met and the HCBS-BI Program Administrator was notified.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the date of their waiting list placement.

**8.515.9 CASE MANAGEMENT FUNCTIONS**

The requirements at Section 8.393 shall apply to the Case Management Agencies performing the case management functions of the HCBS-BI program.

**8.515.10 PROVIDER AGENCIES**

HCBS-BI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

## 8.515.50 ASSISTIVE AND SPECIAL MEDICAL EQUIPMENT

A. DEFINITIONS

Specialized medical equipment and supplies includes 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.

Assistive Devices include equipment which meets one of the following criteria:

1. Is useful in augmenting 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;

2. Is necessary to ensure the health, welfare and safety of the individual;

3. Enables the individual to secure help in the event of an emergency;

4. Is used to provide reminders to the individual of medical appointments, treatments, or medication schedules; or

5. Is required because of the individual's illness impairment or disability, as documented on the screening assessment form and the plan of can.

B. INCLUSIONS

1. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

2. Items which are not of direct medical or remedial benefit to the recipient are excluded.

3. Assistive devices to augment cognitive processes, “cognitive-orthotics” or memory prostheses are included in this service area. Examples of cognitive orthotic devices include informational data bases, spell checkers, text outlining programs, timing devices, security systems, car finders, sounding devices, cuing watches, telememo watches, paging systems, electronic monitoring, tape recorders, electronic checkbooks, electronic medication monitors, and memory telephone.

C. CERTIFICATION REQUIREMENTS

Certification standards refer to both the supplier of equipment as well as the actual product or equipment itself.

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

2. All equipment materials or appliances used as pan of monitoring systems shall carry a UL (Underwriter's Laboratory) number or an equivalent standard.

3. All telecommunications equipment shall be FCC registered.

4. All equipment materials, or appliances shall be installed by properly trained individuals, and the installer shall train the Client in the use of the device.

5. All equipment, materials or appliances shall be tested fir proper functioning at the time of installation and at periodic intervals thereafter by a properly trained individual.

6. Any malfunction shall be promptly repaired by a properly trained technician supplied at the provider agency's expense. Equipment shall be replaced when necessary, including buttons and batteries.

7. Assistive equipment providers shall send written information to each Client's case manager about the item, how it works, and how it should be maintained.

D. REIMBURSEMENT METHOD FOR ASSISTTVE DEVICES

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.

**8.515.70 ADULT DAY SERVICES**

A. DEFINITIONS

1. Adult Day Services means both health and social services furnished on a regularly scheduled basis in an Adult Day Services center two or more hours per day, one or more days per week to ensure the optimal functioning of the client Services are directed towards recreation and socialization as well as maintaining a safe and supportive environment. A participant 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.

   a. Adult Day Services provider means a non-institutional entity that conforms to requirements for maintenance model.

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

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

   Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for participants to engage in activities, with their community, and connect to staff and other ADS participants virtually or over the phone, only if a participant does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services. .

   e. Maintenance Model means services in health monitoring and individual and group therapeutic and psychological activities which serve as an alternative to long-term nursing home care.

2. Adult Day Services include:

   a. Daily monitoring to assure that clients are maintaining personal hygiene and participating in age appropriate social activities as prescribed; and assisting with activities prescribed; and assisting with activities of daily living (e.g., eating, dressing).

   b. Emergency services including whiten procedures to meet medical crises.

c. Assistance in the development of self-care capabilities personal hygiene, and social support services.

d. Provision of nutritional needs appropriate to the hours in which the client is served. Nutrition services are not required during the delivery of Telehealth ADS.

e. Nursing services as necessary to supervise medication regimen of trained medication aides and carry out any of the services listed as SKILLED CARE in SECTION 8.489.30.

f. Social and recreational services as prescribed to meet the client's needs.

g. Documentation specifically stating the types of services and monitoring that were provided when services are provided via Telehealth, ensuring the integrity of the service provided and the benefit that service provides the participant.

B. CERTIFICATION STANDARDS

All Adult Day Service providers shall conform to all of the following Departmental standards

1. All providers must conform to all established departmental standards in the general certification standards section.

2. All providers of Adult Day Services shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The Adult Day Service Center shall provide a clean environment, free of obstacle; that could pose a hazard to client health and safety.

4. Adult Day Service Centers shall provide lockers or a safe place for clients' personal items.

5. Adult Day Service Centers shall provide recreational areas and activities appropriate to the number and needs of the recipients.

6. Adult Day Service Centers shall have drinking facilities located within easy access to clients.

7. Adult Day Service Centers shall provide eating and resting areas consistent with the number and needs of the clients being served.

8. Adult Day Service Centers shall provide easily accessible toilet facilities, hand washing facilities and paper towel dispensers.

9. The center shall be accessible to clients with supportive devices for ambulation or who an in wheelchairs.

C. RECORDS AND INFORMATION

Adult Day Service providers shall keep such records and information necessary to document the services provided to clients receiving Adult Day Services. Medical Information Records shall include but not be limited to:

1. Medications the client is taking and whether they are being self-administered.

2. Special dietary needs, if any.

3. Restrictions on activities identified by physician in the case plan.

D. STAFFING

All Adult Day Service providers shall have staff who have been trained in current cardiopulmonary resuscitation, seizure prophylaxis and control and brain injury. Adequate staff shall available at all times to ensure:

1. Supervision of clients at all times during the operating hours of the program.

2. Immediate response to emergency situations to assure the welfare of clients.

3. Provision of prescribed recreational and social activities.

4. Provision of administrative, recreational, social and supportive functions of the Adult Day Services Center.

E. POLICIES

The Adult Day Service provider shall have a written policy relevant to the operation of the Adult Day Services. Such policy shall include but not be limited to statements describing:

1. Admission criteria that qualify clients to be appropriately served by the provider.

2. Interview procedures conducted for qualified clients and/or family members prior to admission to the provider.

3. The meals and nourishments that will be provided, including special diets, at Center-Based ADS.

4. The hours that the clients will be served by the provider and days of the week services will be available.

5. The personal items participants may bring with them to the center.

6. A written signed contract to be drawn up between the client or responsible party and the Center outlining rules and responsibilities of the provider and of the client. Each party of the contract will have a copy.

7. A statement of the center's policy for providing drop-in care or day respite.

F. REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

1. Reimbursement information for BI ADS is outlined in Section 8.491.5.B.

F. EXCLUSIONS

1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS and therefore are not reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.

## 8.515.80 DAY TREATMENT

A. DEFINITION

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 recipient lives.

B. PROGRAM COMPONENTS, POLICIES AND PROCEDURES

1. Treatment plans are coordinated by a comprehensive interdisciplinary team which includes the recipient and his/her family and provides for consolidation of services in one location.

2. 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.

3. 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 statue.

4. The provider shall network with all allied medical professionals and other community-based resource providers.

5. Services include 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).

6. Crisis situations with family, Client or staff shall be addressed through counseling and referral to appropriate professionals.

7. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

8. There shall be regular contact and meetings with the Clients and their families to discuss treatment plan progress and revision.

9. Discharge planning will include the development of a plan which considers safety, environmental modification to support individual function, education of the family and caregiver, recommendations for the future, and referral to additional community resources.

10. Each entity must have a process, verified in writing, by which a Client is made aware of the process for filing a grievance.

11. Complaints by the Client or family are handled within a 24-hour period from the time of complaint by at least telephone contact.

12. Transportation between therapeutic tasks in the community shall be included in the per diem cost of day treatment.

13. There shall be an inform and consent mechanism by which the Client, family medical proxy or substitute decision maker is made aware of the inherent risks associated with community-based rehabilitation programs. Examples of such risks might include a greater likelihood of falling accidents, traffic hazards and access to drugs or alcohol.

C. HUMAN RIGHTS

Every person receiving HCBS-BI services has the following rights:

1. Every person shall mutually develop and sign their treatment plan.

2. Every person has the right to enjoy freedom of thought, conscience, and religion.

3. Every person has the right to live in a clean, safe environment.

4. Every person has the right to have his or her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his or her life.

5. Every person has the right to be free from physical abuse and inhumane treatment.

6. Every person has the right to be protected from all forms of sexual exploitation.

7. Every person has the right to access necessary medical care which is adequate and appropriate to their condition.

8. Every person has the right to communicate with significant others.

9. Every person has the right to reasonable enjoyment of privacy in personal conversations.

10. Every person has the right to have access to telephones, both to make and receive calls in privacy.

11. Every person has the right to have frequent and convenient opportunities to meet with visitors.

12. Every person has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status, or disability.

13. Every person who acts as his own legal guardian has the right to accept treatment of his/her own free will.

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

15. Every person has the right to be free of physical restraint unless physical intervention is necessary to prevent such body movement that is likely to result in imminent injury to self or others, and only if alternative techniques have failed. Mechanical restraints are not allowed.

D. DOCUMENTATION

1. Intake information shall include a complete neuropsychological assessment and all pertinent medical documentation from inpatient and outpatient therapy and social history to identify key treatment components and communicate the functional implications of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two-week period following admission.

3. Treatment plan goals and objectives shall reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and treatment plans will be reviewed and modified as appropriate.

5. Progress notes will be kept to document specific treatment modalities rendered by date and signed by the therapist providing the service.

E. CERTIFICATION STANDARDS

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. All providers shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The agency shall provide a clean environment, free of obstacles that could pose a hazard to Client health and safety.

4. Agencies shall provide lockers or a safe place for Clients' personal items.

5. Day treatment centers shall provide age appropriate activities and provide eating and resting areas consistent with the number and needs of the Clients being served.

6. The center shall be accessible according to guidelines established by the Americans with Disabilities Act.

7. Personnel shall have training appropriate to the medical needs of the Clients served including seizure management training, CPR certification, non-violent crisis intervention, and personal care standards according to SECTION-PERSONAL CARE 8.489.40.

F. REIMBURSEMENT

Day treatment services will be paid on a per diem basis at a rate to be determined by the Department In order for a provider to be paid for a day of treatment, a Client must have attended and received therapeutic intervention which is substantiated by case file notes signed by the rendering therapist

## 8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.A DEFINITIONS

1. Activities of Daily Living (ADLs) mean basic self-care activities, including mobility, bathing, toileting, dressing, eating, transferring, support for memory and cognition, and behavioral supervision.

2. Assistance means the use of manual methods to guide or assist with the initiation or completion of voluntary movement or functioning of an individual's body through the use of physical contact by others, except for the purpose of providing physical restraint.

3. Assistive Technology Devices means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

4. Authorized Representative means an individual designated by the Client or the legal guardian, if appropriate, who has the judgment and ability to assist the Client in acquiring and utilizing supports and services.

5. Behavioral Management and Education means services as defined in § 8.516.40.A, and Inclusions as defined at § 8.516.40.B, provided as an individually developed intervention designed to decrease/control the Client's severe maladaptive behaviors which, if not modified, will interfere with the Client's ability to remain integrated in the community.

6. Case Management Agency (CMA) means an agency within a designated service area where an applicant or Client can obtain Case Management services. CMAs include Single Entry Points (SEPs), Community Centered Boards (CCBs), and private case management agencies.

7. Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual Client's functional eligibility for the Home and Community-based Services – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and person-centered Service Plan for the Client, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such Client's needs.

8. Critical Incident means an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a Client that could have, or has had, a negative impact on the mental and/or physical well-being of a Client in the short or long-term. A critical incident includes accidents, a suspicion of, or actual abuse, neglect, or exploitation, and criminal activity.

9. Department means the Department of Health Care Policy and Financing.

10. Health Maintenance Activities means those routine and repetitive health-related tasks which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These activities include, but are not limited to, catheter irrigation, administration of medication, enemas, suppositories, and wound care.

11. Independent Living Skills Training means services designed and directed toward the development and maintenance of the Client's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

12. 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.

13. Interdisciplinary Team means a group of people responsible for the implementation of a Client's individualized care plan, which includes the Client receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by the Client's needs and preferences, who are assembled in a cooperative manner to develop or review the person-centered care plan.

14. Personal Care Services includes providing assistance with eating, bathing, dressing, personal hygiene or other activities of daily living. When specified in the service plan, Personal Care Services may also include housekeeping chores such as bed making, dusting, and vacuuming. Housekeeping assistance must be incidental to the care furnished or essential to the health and welfare of the individual rather than for the benefit of the individual's family.

15. Person-Centered Care Plan is a service plan created by a process that is driven by the individual and can also include people chosen by the individual pursuant to 42 C.F.R. § 441.540. It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents Client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the Client needs to function safely in the community.

16. Protective Oversight is defined as monitoring and guidance of a Client to assure his/her health, safety, and well-being. Protective oversight includes, but is not limited to: monitoring the Client while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the Client to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the Client's choice and ability to travel and engage independently in the wider community and providing guidance on safe behavior while outside the Supportive Living Program.

17. Room and Board is defined as a comprehensive set of services that include lodging, routine or basic supplies for comfortable living, and nutritional and healthy meals and food for the Client, all of which are provided by the Supportive Living Program provider, and are not included in the per diem.

18. Supportive Living Program (SLP) certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to the Department after the SLP provider has met all licensing requirements found in 6 C.C.R. 1011-1; Chapter 2, and either Chapter 7 or 26, in addition to all requirements in § 8.515.85.

8.515.85.B CLIENT ELIGIBILITY

1. SLP services are available to individuals who meet all of the following requirements:

    a. Clients are determined functionally eligible for HCBS-BI waiver by a certified case management agency;

b. Clients are enrolled in the HCBS-BI waiver; and

c. Clients require the specialized services provided under the SLP as determined by assessed need.

8.515.85.C SUPPORTIVE LIVING PROGRAM INCLUSIONS

1. SLP services consist of structured services designed to provide:

a. Assessment;

b. Protective Oversight and supervision;

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.

2. Person-Centered Care Planning

SLP providers must comply with the Person-Centered Care Planning process. Providers must work with CMAs to ensure coordination of a Client's Person-Centered Care Plan. Additionally, SLP providers must provide the following actionable plans for all HCBS-BI waiver Clients, updated every six (6) months:

a. Transition Planning; and

b. Goal Planning.

These elements of a Person-Centered Care Plan are intended to ensure the Client actively engages in his or her care and activities, as is able to transition to any other type of setting or service at any given time.

3. Exclusions

The following are not included as components of the SLP:

a. Room and board; and

b. Additional services which are available as a State Plan benefit or other HCBS-BI waiver service. Examples include, but are not limited to physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, long-term home health, and private duty nursing.

8.515.85.D PROVIDER LICENSING AND CERTIFICATION REQUIREMENTS

1. To be certified as an SLP provider, the entity seeking certification must be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. 7, except as provided below.

   a. Subject to Department approval, providers that have been in continuous operation at the same address prior to 1987 may continue to furnish SLP services under a Home Care Agency (HCA) license pursuant to 6 CCR 1011-1, Ch. 26 instead of the ALR license.

      i. Providers furnishing SLP services under a Department-approved exception are required to comply with this § 8.515.85, regardless of licensure type.

      ii. Providers furnishing SLP services under a Department-approved exception are required to comply with the medication administration requirements pursuant to both the HCA licensure requirements found at 6 CCR 1011-1, Chapters 7 and 26, and Section 25-1.5-301 through 304, C.R.S. 6 CCR 1011-1, Ch. 7, Section 14, (2018) is hereby incorporated by reference. The incorporation of this regulation 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. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. In addition to the requirements of § 8.515.85.D.1, SLP providers must also receive SLP Certification from CDPHE. CDPHE issues or renews a Certification when the provider is in full compliance with the requirements set out in these regulations. Certification is valid for three years from the date of issuance unless CDPHE revokes, suspends, or takes other disciplinary action against the licensee, or the certification is voluntarily relinquished by the provider.

3. No Certification shall be issued or renewed by CDPHE if the owner, applicant, or administrator of the SLP has been convicted of a felony or of a misdemeanor, which felony or misdemeanor involves moral turpitude or involves conduct that the Department determines could pose a risk to the health, safety, or welfare of residents of the assisted living residence.

8.515.85.E PROVIDER RESPONSIBILITIES

SLP providers must follow all person-centered planning initiatives undertaken by the State to ensure Client choice.

8.515.85.F HCBS PROGRAM CRITERIA

1. In accordance with 42 C.F.R. § 441.530, Home and Community-based settings must:

   a. Be integrated in and support full access to the greater community;

   b. Be selected by the Client from among setting options;

   c. Ensure Client rights of privacy, dignity, and respect, and freedom from coercion and restraint;

   d. Optimize individual initiative, autonomy, and independence in making life choices;

   e. Facilitate Client choice regarding services and supports, and who provides them;

   f. Be a specific, physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, 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;

   g. Ensure privacy in the Client's unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;

   h. Ensure that Clients have the freedom and support to control their own schedules and activities, and have access to food at any time;

   i. Ensure each Client has the right to receive and send packages. No Client's outgoing packages shall be opened, delayed, held, or censored by any person;

   j. Ensure each Client has the right to receive and send sealed, unopened correspondence. No Client's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person;

   i. Enable Clients to have visitors of their choosing at any time; and

   j. Be physically accessible.

2. Exceptions

   The Department may grant exceptions to HCBS Program Criteria listed in § 8.515.85.F.1, a through h, when reasonable, as follows:

   a. Requirements of program criteria may be modified if supported by a specific assessed need and justified in the person-centered care plan. The following requirements must be documented in the person-centered care plan:

      i. Identify a specific and individualized assessed need.

      ii. Document the positive interventions and supports used prior to any modifications to the person-centered care plan.

      iii. Document less intrusive methods of meeting the need that have been tried but did not work.

iv. Include a clear description of the modification that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

viii. Include an assurance that interventions and supports will cause no harm to the individual.

b. HCBS Program Criteria under 8.515.85.F.1.b and e:

i. When a Client chooses to receive HCBS in a provider-owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the Client cannot choose an alternative provider to deliver services that are included in the bundled rate.

ii. For any services that are not included in the bundled rate, the Client may choose any qualified provider, including the provider who controls or owns the setting, if the provider offers the service separate from the bundle.

c. HCBS Program Criteria under 8.515.85.F.1.c:

When a Client needs assistance with challenging behavior, including a Client whose behavior is dangerous to himself, herself, or others, or when the Client engages in behavior that results in significant property destruction, the SLP must create detailed service and support plans that describe how to appropriately address these behaviors.

d. HCBS Program Criteria under 8.515.85.F.1.g:

Requirements for a lockable entrance door may be modified if supported by a specific assessed need and justified in the person-centered service plan.

8.515.85.G STAFFING

1. The SLP provider shall ensure sufficient staffing levels to meet the needs of Clients.

2. The operator, staff, and volunteers who provide direct Client care or protective oversight must be trained in precautions and emergency procedures, including first aid, to ensure the safety of the clientele.

3. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 6, 7, and 8, (2018) which are hereby incorporated by reference. The incorporation of this regulation 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. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

4. Within one month of the date of hire, the SLP provider shall provide adequate training for staff on each of the following topics:

   a. Crisis prevention;

   b. Identifying and dealing with difficult situations;

   c. Cultural competency;

   d. Infection control; and

   e. Grievance and complaint procedures.

5. Prior to providing direct care, the SLP provider shall provide to the operator, staff, and volunteers an orientation to the location in which the program operates, and adequate training on person-centered care planning.

6. All staff training shall be documented. Copies of person-centered care plan training and related documentation must be submitted to the Department upon request. Prior to any subsequent change in the training curriculum, the provider must submit copies to the Department for review and approval.

7. 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.

8. The provider shall employ or contract for behavioral services and skill training services according to Client needs.

9. The SLP shall ensure that provision of services is not dependent upon the use of Clients to perform staff functions. Volunteers may be utilized in the home but shall not be included in the provider’s staffing plan in lieu of employees.

10. The SLP provider shall maintain written personnel policies and shall provide a copy of these policies to each staff member upon employment. The administrator or designee shall explain such policies during the initial staff orientation period.

11. The SLP provider shall conduct a criminal background check through the Colorado Bureau of Investigation for all staff, prospective staff, and volunteers. The provider shall not employ any person convicted of an offense that could pose a risk to the health, safety, and welfare of Clients. The provider shall bear all costs related to obtaining a criminal background check.

8.515.85.H CLIENT RIGHTS AND PROPERTY

1. Clients shall have all rights stated in § 8.515.85.F.1.

2. Any provider that chooses to handle Client funds and property must maintain policies and practices for management of Client funds and property that are consistent with those at 6 CCR 1011-1, Ch. 7, Section 11.10.

3. Upon Client request, a Client shall be entitled to receive, and the provider shall promptly deliver, available money or funds held in trust.

8.515.85.I FIRE SAFETY AND EMERGENCY PROCEDURES

1. Applicants for initial provider Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by DFPC.

    a. The Department may grant an exception to this provision for a provider qualified under § 8.515.85.D.1.c, if the provider holds a current certificate of compliance from the local fire authority.

3. Providers shall develop written emergency plans and procedures for fire, serious illness, severe weather, disruption of essential utility services, and missing persons for each Client. Emergency and evacuation procedures shall be consistent with any relevant local and state fire and life safety codes and the provisions set forth in 6 CCR 1011-1 Ch. 7, § 10.

4. Within three (3) days of scheduled work or commencement of volunteer service, the program shall provide adequate training for staff in emergency and fire escape plan procedures.

5. SLP providers must train all staff and Clients on emergency plans and procedures at intervals throughout the year. Providers shall conduct fire drills at least once every six (6) months, during the evening and overnight hours while Clients are sleeping. All such practices and training shall be documented and reviewed every six (6) months. Such documentation shall include any difficulties encountered and any needed adaptations to the plan. Such adaptations shall be implemented immediately upon identification.

8.515.85.J ENVIRONMENTAL AND MAINTENANCE REQUIREMENTS

1. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 15,16, 17, and 19, (2018) which are hereby incorporated by reference. The incorporation of this regulation 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. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. The interior and exterior environment of the SLP residence shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 20, 21, 22, 23, and 24, (2018) which are hereby incorporated by reference. The incorporation of this regulation 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. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

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

4. SLP providers shall develop and implement procedures for the following:

    a. Handling of soiled linen and clothing;

    b. Storing personal care items;

c. General cleaning to minimize the spread of pathogenic organisms; and

d. Keeping the home free from offensive odors and accumulations of dirt and garbage.

5. The SLP provider shall ensure that each Client is furnished with his or her own personal hygiene and care items. These items are to be considered basic in meeting an individual's needs for hygiene and remaining healthy. Any additional items may be selected and purchased by the Client at his or her discretion.

6. There shall be adequate bathroom facilities for individuals to access without undue waiting or burden.

7. Each Client shall have access to telephones, both to make and to receive calls in privacy.

8.515.85.K COMPLAINTS AND GRIEVANCES

Each Client will have the right to voice grievances and recommend changes in policies and services to both the Department and/or the SLP provider. Complaints and grievances made to the Department shall be made in accordance with the grievance and appeal process in § 8.209.

8.515.85.M RECORDS

1. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Section 18, (2018) which are hereby incorporated by reference. The incorporation of this regulation 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. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. Supportive Living Providers shall develop policies and procedures to secure Client information against potential identity theft. Confidentiality of medical records shall be maintained in compliance with 45 C.F.R. § 160.101, et seq.

3. All medical records for adults (persons eighteen (18) years of age or older) shall be retained for no less than six (6) years after the last date of service or discharge from the SLP. All medical records for minors shall be retained after the last date of service or discharge from the SLP for the period of minority plus six (6) years.

8.515.85.N REIMBURSEMENT

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

2. The methodology for calculating the per diem rate shall be based on a weighted average of Client acuity scores.

3. The Department shall establish a maximum allowable room and board charge for Clients in the SLP. Increases in payment shall be permitted in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises grant amounts.

a. Room and board shall not be a benefit of HCBS-BI residential services. Clients shall be responsible for room and board in an amount not to exceed the Department-established rate.

8.515.85.O CALCULATION OF CLIENT PAYMENT (PETI)

1. When a Client has been determined eligible for HCBS-BI under the 300% income standard§, the State may reduce Medicaid payment for SLP residential services. The case manager shall calculate the Client payment (PETI) for 300% eligible HCBS-BI Clients according to the following procedures:

a. For 300% eligible Clients who receive residential services, the case manager shall complete a State-prescribed form which calculates the Client payment according to the following procedures:

i. An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the Client's gross income to be used as the Client maintenance allowance, from which the state-prescribed HCBS residential services room and board amount shall be paid, and

ii. For an individual with financial responsibility for others:

1) If the individual is financially responsible for only a spouse, an amount equal to the state Aid to the Needy Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the Client's gross income; or

2) 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 § 8.100.1, who is either a full-time student or a part-time student§) shall be deducted from the Client's gross income.

iii. Expenses incurred for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the Client's gross income as follows:

1) If health insurance coverage is documented in the eligibility system, health insurance premiums, deductible and co-insurance charges, 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 need for such medications shall be documented in writing by the attending physician. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change in medications.

b) The cost for medications which may be purchased with the Client's Medicaid Identification Card shall not be allowed as deductions.

c) The cost for medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

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

e) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

5) The cost for other necessary medical or remedial care shall be deducted from the Client's gross income, with the following limitations:

a) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. 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) The cost for any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

6) 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.

7) 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.

iv. Any remaining income shall be applied to the cost of the SLP residential services, as described at § 8.515.85.C, and shall be paid by the Client directly to the facility; and

v. If there is still income remaining after the entire cost of residential services are paid from the Client's income, the remaining income shall be kept by the Client and may be used as additional personal needs or for any other use that the Client desires, except that the residential service provider shall not charge more than the Medicaid rate for that service.

b. Case managers shall inform HCBS-BI Clients receiving residential services of their Client payment obligation on a form prescribed by the state at the time of the first assessment visit, by the end of each plan period. Whenever there is a significant change in the Client payment amount that affects the Client's payment obligation, the case manager must inform the Client of the change in payment within ten (10) working days,.

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

ii. Copies of Client payment forms shall be kept in the Client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request under § 8.515.7, or if requested by the state for monitoring purposes.

## 8.516.10 INDEPENDENT LIVING SKILLS TRAINING

A. DEFINITIONS

1. Independent Living Skills Training (ILST) means services designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community. ILST may be provided in the Client's residence, in the community, or in a group living situation.

2. ILST program service plans are plans that describe the ILST services necessary to enable the Client to independently sustain himself/herself physically, emotionally, and economically in the community. This plan is developed with the Client and the provider.

3. ILST Trainers are individuals trained in accordance with guidelines listed below tasked with providing the service inclusions to the program participant.

4. Person-Centered Care 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 independent living ILST trainer(s). It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents Client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the Client needs to function safely in the community. This plan is developed by the Client with the case management agency.

B. INCLUSIONS

1. Reimbursable services are limited to the 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 care plan. Reimbursement is limited to services described in the person-centered care plan.

C. PROVIDER CERTIFICATION STANDARDS

1. Provider agencies must have valid licensure and 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 provider 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 program service plans to ensure Client plan is designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

c. Any component of the ILST plan that may contain activities outside the scope of the ILST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the Client. 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 plan may include individuals who are members of agency staff, contracted staff, or external licensed and certified professionals who are fully aware of duties conducted by ILST trainers.

e. All ILST 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 8.516.10.C.1.c.i-ix.

2. ILST trainers must meet one of the following education, experience, or certification requirements:

a. Licensed health care professionals with experience in providing functionally based assessments and skills training for individuals with disabilities; or

b. Individuals with a bachelor's degree and one 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 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 3 years of experience providing services similar to ILST services; or

e. Individuals with 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 agency shall administer a series of training programs to all ILST trainers.

a. Prior to delivery of and reimbursement for any services, ILST trainers must complete the following trainings:

i. Person-centered care approaches; and

ii. HIPAA and Client confidentiality; and

iii. Basics of brain injury including at a minimum;

1. Basic neurophysiology; and

2. Impact of a brain injury on an individual; and

3. Epidemiology of brain injury; and

4. Common physical, behavioral, and cognitive impairments and interactions strategies; and

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; and

v. Basic safety and de-escalation techniques; and

vi. Training on community and public resource availability; and

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; and

ii. Updates on brain injury recovery guidelines; and

iii. Updates on resource availability.

D. REIMBURSEMENT

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

**8.516.30 TRANSITIONAL LIVING**

A. DEFINITIONS

1. Transitional living means programs, which occur outside of the Client's residence, designed to improve the Client's ability to live in the community by provision of 24-hour services, support and supervision.

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 therapy needs mean, for purposes of this program, a Client 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.

B. INCLUSIONS

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

2. Clients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs.

3. Clients must require available paraprofessional nursing assistance on a 24-hour basis due to dependence in activities of daily living, locomotion, or cognition.

4. 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 Client 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 Client must be documented and authorized individually by the Department.

C. EXCLUSIONS

1. 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.

2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.

3. Room and board charges are not a billable component of transitional living services.

4. Items of personal need or comfort shall be paid out of money set aside from the Client's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program.

5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the Department.

D. CERTIFICATION STANDARDS

Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-27-104.

1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs.

2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in the following sections entitled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS.

3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards.

4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis.

5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

2. Clients, families, medical proxies, or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

3. Understanding that Clients of transitional living programs frequently experience behavior which may be a danger to himself/herself or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a Client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.

4. 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 Clients for whom they lack adequate resources to ensure safety of program participants and staff.

5. Upon entry into the program, discharge planning shall begin with the Client and family. Transitional living programs shall work with the Client 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 services.

6. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

7. During daytime hours, the ratio of staff to Clients 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.

8. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Department.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service-related profession plus three years of experience providing direct services to individuals with 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.

2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the Client. These staff members will have successfully completed a training program of at least 40 hours duration.

3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.

4. The operator, staff, and volunteers who provide direct Client care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from impatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two-week period following admission.

3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.

5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

6. All transitional services must utilize licensed psychologists win two years of experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the Client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.

7. Programs shall have a process verified in writing by which a Client is made aware of the process for filing a grievance. Complaints by the Client or family shall be handled via telephone or direct contact with the Client or family.

8. Customer satisfaction surveys will be regularly performed and reviewed.

9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.

10. Client safety in the community will be assessed: safety status and recommendations will be documented.

11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.

2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the acuity-based per diem reimbursement rate established by the Department.

Providers shall not charge a Medicaid participant more than the Department’s annually established room and board rate.

All transitional living services shall be prior authorized through submission to the Department. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond a duration of 180 days must be reauthorized with treatment plan justification and shall be submitted through the reconsideration process established by the Department.

### 8.516.40 BEHAVIORAL PROGRAMMING

A. DEFINITION

Behavioral programming and education is an individually developed intervention designed to decrease/control the Client's severe maladaptive behaviors which, if not modified, will interfere with the individuals ability to remain integrated in the community.

B. 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 person's environment.

2. Behavioral programs may be provided in the community or in the Client's residence unless the residence is a transitional living center which provides behavioral intervention as a treatment component

3. All behavioral programming must be documented in the plan of care and reauthorized after 30 units of service with the Brain Injury Program Coordinator.

C. CERTIFICATION STANDARDS

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 health care professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters 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 same.

D. REIMBURSEMENT

Behavioral programming must be documented on the Client's care plan and prior authorized through the State Brain Injury Program Coordinator. Behavioral programming services will be paid on an hourly basis as established by the Department

### 8.516.50 COUNSELING

A. DEFINITIONS

Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries.

B. INCLUSIONS

1. Counseling is available to the program participant's family in conjunction with the Client if they: a) have a significant role in supporting the Client or b) live with or provide care to the Client. “Family” includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the waiver participant.

2. Services may be provided in the waiver participant'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. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department as directed by certification standards listed below.

5. Family training/counseling must be carried out for the direct benefit of the Client of the HCBS-BI 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 plan of care and shall include updates as may be necessary to safely maintain the individual at home.

7. Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

1. Family training is not available to individuals who are employed to care for the recipient.

D. CERTIFICATION STANDARDS

1. Professionals providing counseling 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.

2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years of experience in providing counseling to individuals with brain injury and their families.

3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling, Individual Counseling, and Group Counseling.

## 8.516.60 SUBSTANCE ABUSE COUNSELING

A. DEFINITION

Substance abuse programs are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the water participant which, if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

B. INCLUSIONS

1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program

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 participant, 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 Client, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager.

3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall he submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

Inpatient treatment is not a covered benefit.

D. CERTIFICATION STANDARDS

1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing.

2. Programs 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 individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury.

3. Counselors should be certified at the Certified Addiction Counselor II 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 individual with a brain injury or their family members. A recommended training curriculum will include a three-day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years.

E. REIMBURSEMENT

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

**8.516.70 RESPITE CARE**

A. DEFINITIONS

1. Respite care means services provided to an eligible Client on a short-term basis because of the absence or need for relief of those persons normally providing the care.

2. Respite care provider means a Class I nursing facility, an alternative care facility or an employee of a certified personal care agency which meets the certification standards for respite care specified below.

B. INCLUSIONS

1. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite Client, as ordered by the physician.

C. RESTRICTIONS

1. An individual Client shall be authorized for no more than a cumulative total of thirty (30) days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home and in a nursing facility.

   A. A mix of delivery options is allowable if the aggregate amount of services is below thirty (30) days, or 720 hours, of respite care.

      1. In home respite is limited to no more than eight (8) hours per day.

      2. Nursing facility respite billed on a per diem.

2. Only those portions of the facility that are Medicaid certified for nursing facility services may be utilized for respite Clients.

D. CERTIFICATION STANDARDS AND PROCEDURES

1. Respite care standards and procedures for nursing facilities are as follows:

   A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

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

   C. For each HCBS-BI respite Client, 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 Client. The chart must identify the Client as a respite Client. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

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

E. The nursing facility shall have written policies and procedures available to staff regarding respite care Clients. 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 Clients.

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

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

E. REIMBURSEMENT

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

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

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

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

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

A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-BI claim form according to fiscal agent instructions.

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

C. Reimbursement shall be the lower of billed charges; or the 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.

3. Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

4. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI services shall not be reimbursed during the respite stay.

5. There shall be no reimbursement provided under this section for respite care in uncertified, congregate facilities.

## 8.517 HOME AND COMMUNITY-BASED SERVICES FOR THE COMPLEMENTARY AND INTEGRATIVE HEALTH WAIVER

### 8.517.1 HCBS-CIHWAIVER SERVICES

### 8.517.1.A SERVICES PROVIDED

1. Acupuncture (CIHS)
2. Adult Day Services
3. Chiropractic (CIHS)
4. Consumer Directed Attendant Support Services (CDASS)
5. Electronic Monitoring
6. Home Delivered Meals
7. Home Modification
8. Homemaker Services
9. In-Home Support Services
10. Life Skills Training (LST)
11. Massage Therapy (CIHS)
12. Non-Medical Transportation
13. Peer Mentorship
14. Personal Care Services
15. Respite Care
16. Transition Setup

### 8.517.1.B DEFINITIONS OF SERVICES

1. Acupuncture (CIHS) means services as defined at Section 8.517.2.A.
2. Adult Day Services means services as defined at Section 8.491.
3. Chiropractic (CIHS) means services as defined at Section 8.517.2.B.
4. Complementary and Integrative Health Services (CIHS) means services as defined at Section 8.517.B.E.
5. Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.
6. Electronic Monitoring means services as defined at Section 8.488.

7. Home Delivered Meals means services as defined at Section 8.553.

8. Home Modification means services as defined at Section 8.493.

9. Homemaker Services means services as defined at Section 8.490.

10. In-Home Support Services means services as defined at Section 8.552.

11. Life Skills Training (LST) means services as defined at Section 8.553.

12. Massage Therapy (CIHS) means services as defined at Section 8.517.2.H.

13. Non-Medical Transportation means services as defined at Section 8.494.

14. Peer Mentorship means services as defined at Section 8.553.

15. Personal Care Services means services as defined at Section 8.489.

16. Respite Care means services as defined at Section 8.492.

17. Transition Setup means services as defined at Section 8.553.

**8.517.2 GENERAL DEFINITIONS**

A. Acupuncture (CIHS) 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.

B. Chiropractic (CIHS) 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.

C. Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.

D. Complementary and Integrative Health Provider means an individual or agency certified annually by the Department to have met the certification standards listed at Section 8.517.11.

E. Complementary and Integrative Health Services (CIHS) means Acupuncture, Chiropractic, and Massage Therapy.

F. Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

G. Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

H. Massage Therapy (CIHS) 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/or psychological changes.

**8.517.3 LEGAL BASIS**

The Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CIH program is also authorized under state law at C.R.S. section 25.5-6-1301 et seq. – as amended.

**8.517.4 SCOPE AND PURPOSE**

8.517.4.A. The Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver provides assistance to individuals living with a qualifying condition of a spinal cord injury, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability for independent ambulation directly resulting from one of these conditions that require long-term supports and services in order to remain in a community setting.

8.517.4.B. The HCBS-CIH waiver provides an opportunity to study the effectiveness of Complementary and Integrative Health Services and the impact the provision of these service may have on the utilization of other HCBS-CIH waiver and/or acute care services.

8.517.4.C. An independent evaluation shall be conducted no later than January 1, 2025 to determine the effectiveness of the Complementary and Integrative Health Services.

**8.517.5 CLIENT ELIGIBILITY**

8.517.5.A. ELIGIBLE PERSONS

Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services shall be offered only to individuals who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a qualifying condition of a spinal cord injury (traumatic or nontraumatic), multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability for independent ambulation directly resulting from one of these conditions as defined by broad diagnoses related to each condition within the most current version of the International Classification of Diseases (ICD) at the time of assessment.

3. Individuals must have been determined to have an inability for independent ambulation resulting from the qualifying condition as identified by the case manager through the assessment process. The inability for independent ambulation means:

   a. The individual does not walk, and requires use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own, OR;

   b. The individual does walk, but requires use of a walker or cane in all settings, whether or not they can use the walker or cane safely, on their own, OR;

c. The individual does walk, but requires “touch” or “stand-by” assistance to ambulate safely in all settings.

8.517.5.B FINANCIAL ELIGIBILITY

Individuals must meet the financial eligibility requirements specified at Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.517.5.C LEVEL OF CARE CRITERIA

Individuals shall require long-term support services at a level of care comparable to services typically provided in a nursing facility or hospital.

8.517.5.D NEED FOR HOME AND COMMUNITY-BASED SERVICES FOR COMPLEMENTARY AND INTEGRATIVE HEALTH (HCBS-CIH) WAIVER SERVICES

1. Only individuals that currently receive Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services, or that have agreed to accept HCBS-CIH services as soon as all other eligibility criteria have been met, are eligible for the HCBS-CIH waiver.

    a. Case management is not a HCBS-CIH service and shall not be used to satisfy this requirement.

    b. The desire or need for any Medicaid services other than HCBS-CIH waiver services, as listed at Section 8.517.1, shall not satisfy this eligibility requirement.

2. Individuals that have not received at least one (1) HCBS-CIH waiver service for a period greater than 30 consecutive days shall be discontinued from the waiver.

8.517.5.E EXCLUSIONS

1. Individuals who are residents of nursing facilities or hospitals are not eligible to receive Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services.

2. HCBS-CIH Clients that enter a nursing facility or hospital may not receive HCBS-CIH waiver services while admitted to the nursing facility or hospital.

    a. HCBS-CIH Clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-CIH program.

    b. HCBS-SCI Clients entering a nursing facility for Respite Care as an HCBS-CIH service shall not be discontinued from the HCBS-CIH program.

8.517.5.F COST CONTAINMENT AND SERVICE ADEQUACY

1. Individuals shall not be eligible for the Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver if the case manager determines any of the following during the initial assessment and service planning process:

    a. The individual’s needs cannot be met within the Individual Cost Containment Amount.

b. The individual's needs are more extensive than HCBS-CIH waiver services can support and/or that the individual's health and safety cannot be assured in a community setting.

2. Individuals shall not be eligible for the HCBS-SCI waiver at reassessment if the case manager determines the individual's needs are more extensive than HCBS-CIH waiver services are able to support and/or that the individual's health and safety cannot be assured in a community setting.

3. Individuals may be eligible for the HCBS-CIH waiver at reassessment if the case manager determines that HCBS-CIH waiver services are able to support the individual's needs and the individual's health and safety can be assured in a community setting.

a. If the case manager expects that the services required to support the individual's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the support plan to determine if the individual's request for services is appropriate and justifiable based on the individual's condition.

i) Individuals may request of the case manager that existing services remain intact during this review process.

ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:

1) Long-Term Care Notice of Action Form (LTC-803), informing the Client of the denial and providing the Client's appeal rights pursuant to Section 8.057; and

2) Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

**8.517.6 WAITING LIST**

1. The number of Clients who may be served through the Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver during a fiscal year may be limited by the federally approved waiver.

2. Individuals determined eligible for the HCBS-CIH waiver who cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

3. The waiting list shall be maintained by the Department.

4. The case manager shall ensure the individual meets all eligibility criteria as set forth at Section 8.517.5 prior to notifying the Department to place the individual on the waiting list.

5. The date the case manager determines an individual has met all eligibility requirements as set forth at Section 8.517.5 is the date the Department will use for the individual's placement on the waiting list.

6. When an eligible individual is placed on the waiting list for the HCBS-CIH waiver, the case manager shall provide a written notice of the action in accordance with section 8.057 et seq.

7. As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for the HCBS-CIH waiver in the order of the individual's placement on the waiting list

8. When an opening for the HCBS-CIH waiver becomes available the Department will provide written notice to the Case Management Agency.

9. Within ten business days of notification from the Department that an opening for the HCBS-CIH waiver is available the Case Management Agency shall:

    a. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

    b. Update the existing functional level of care assessment in the official Client record if less than six months has elapsed since the date of the previous assessment.

    c. Reassess for eligibility criteria as set forth at 8.517.5.

    d. Notify the Department of the individual's eligibility status.

**8.517.7 START DATE FOR SERVICES**

8.517.7.A. The start date of eligibility for Home and Community-Based Services for Complementary and Integrative Health (HCBS-CIH)waiver services shall not precede the date that all of the requirements at Section 8.517.5, have been met. The first date for which HCBS-CIH waiver services may be reimbursed shall be the later of the following:

1. The date at which financial eligibility is effective.

2. The date at which the level of care and targeting criteria are certified.

3. The date at which the individual agrees to accept services and signs all necessary intake and service planning forms.

4. The date of discharge from the hospital or nursing facility.

**8.517.8 CASE MANAGEMENT FUNCTIONS**

8.517.8.A. The requirements at Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH)waiver.

**8.517.9 PRIOR AUTHORIZATION OF SERVICES**

8.517.9.A. All Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services must be prior authorized by the Department or its agent.

8.517.9.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.517.9.C. Claims for services are not reimbursable if:

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

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

3. Services are duplicative of other services included in the Client's Support Plan;

4. The Client is receiving funds to purchase services; or

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

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

8.517.9.E. Payment for HCBS-CIH waiver services is also conditional upon:

a. The Client's eligibility for HCBS-CIH waiver services;

b. The provider's certification status; and

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

8.517.9.F. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulation and necessary to meet the Client's needs.

8.517.9.G. Services requested on the PAR shall be supported by information on the Long-term Care Support Plan and written documentation from the income maintenance technician of the Client's current monthly income.

8.517.9.H. The PAR start date shall not precede the start date of HCBS-CIH eligibility in accordance with Section 8.517.7.

8.517.9.I. The PAR end date shall not exceed the end date of the HCBS-CIH eligibility certification period.

## 8.517.10 PROVIDER AGENCIES

8.517.10.A. HCBS-SCI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

## 8.517.11 COMPLEMENTARY AND INTEGRATIVE HEALTH SERVICES

Complementary and Integrative Health Services are limited to Acupuncture, Chiropractic Care, and Massage Therapy as defined at Section 8.517.2.

8.517.11.A. Inclusions

1. Acupuncture used for the treatment of conditions or symptoms related to the Client's qualifying condition and inability to independently ambulate.

2. Chiropractic Care used for the treatment of conditions or symptoms related to the Client's qualifying condition and inability to independently ambulate.

3. Massage Therapy used for the treatment of conditions or symptoms related to the Client's qualifying condition and inability to independently ambulate.

8.517.11.B. Exclusions / Limitations

1. Complementary and Integrative Health Services shall be provided only for the treatment of conditions or symptoms related to the Client's qualifying condition and inability to independently ambulate.

2. Complementary and Integrative Health Services shall be limited to the Client's assessed need for services as determined by the Complementary and Integrative Health Provider and documented in the Complementary and Integrative Health Care Plan.

3. Complementary and Integrative Health Services shall be provided in an approved outpatient setting in accordance with 8.517.11.C.2 or in the Client's residence.

4. Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.C.

5. Clients receiving Complementary and Integrative Health Services shall participate in an independent evaluation to determine the effectiveness of the services.

6. The Complementary and Integrative Health Services benefit is limited as follows:

   a. A Client may receive each of the three individual Complementary and Integrative Health Services on a single date of service.

   b. A Client shall not receive more than four (4) units of each individual Complementary and Integrative Health Service on a single date of service.

   c. A Client shall not receive more than 204 units of a single Complementary and Integrative Health service during a 365-day certification period.

   d. A Client shall not receive more than 408 combined units of all Complementary and Integrative Health Services during a 365-day certification period.

8.517.11.C. Certification Standards

1. Organization and Staffing

   a. Complementary and Integrative Health Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.

   b. Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (C.R.S § 12-200-101 et seq) and have at least (1) year 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.

c. Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (C.R.S. § 12-215-101 et seq) and have at least (1) year experience practicing Chiropractic at a rate of 520 hours per year; OR (1) year of experience working with individuals with paralysis or other long term physical disabilities.

d. Massage Therapists shall be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (C.R.S. § 12-235-101, et seq) and have at least (1) year experience practicing Massage Therapy at a rate of 520 hours per year; OR (1) year of experience working with individuals with paralysis or other long term physical disabilities.

2. Environmental Standards for Complementary and Integrative Health Services provided in an outpatient setting.

a. Complementary and Integrative Health Providers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. They shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.

b. Policies shall be developed and procedures implemented for the effective control of insects, rodents, and other pests.

c. All wastes shall be disposed in compliance with local, state and federal laws.

d. A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.

e. Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.

f. Outpatient settings shall be constructed and maintained to ensure access and safety.

g. Outpatient settings shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.

3. Failure to comply with the requirements of this rule may result in the revocation of the Complementary and Integrative Health Provider certification.

8.517.11.D COMPLEMENTARY AND INTEGRATIVE HEALTH CARE PLAN

1. Complementary and Integrative Health Providers shall:

a. Guide the development of the Complementary and Integrative Health Care Plan in coordination with the client and/or client’s representative.

b. Recommend the appropriate modality, amount, scope, and duration of the Complementary and Integrative Health Service(s) within the established limits as listed at 8.517.11.B.

c. Recommend only services that are necessary and appropriate and will be rendered by the recommending Complementary and Integrative Health Provider.

d. Maintain client records as established at Section 8.487.16. Client records shall be made available to the Department or designated entity upon request and demonstrate the completion of Complementary and Integrative Health Providers requirements above.

2. The Complementary and Integrative Health Provider shall reassess the Complementary and Integrative Health Care Plan annually or more frequently as necessary. The reassessment shall include a visit with the client.

3. The Complementary and Integrative Health Care Plan shall be developed using Department prescribed form(s) or template(s).

4. The Complementary and Integrative Health Care Plan shall include the amount, scope, and duration of recommended Complementary and Integrative Health Services (CIHS).

5. Recommendations for CIHS on the Complementary and Integrative Health Care Plan will guide case managers in completing the Prior Authorization Request (PAR).

6. CIHS will be added to the PAR only if recommended in the Complementary and Integrative Health Care Plan and agreed to by the client.

**8.518 [Repealed eff. 09/30/2016]**

## 8.519 Case Management

### 8.519.1 Definitions

A. Adverse Action means a denial, reduction, termination, or suspension from a long-term service and support program or service.

B. Agency Applicant means an entity seeking approval to be a provider of case management services for Home and Community-Based Services.

C. Algorithm means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Clients into one of six support levels in the Home and Community-based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Communitybased Services- Supported Living Services (HCBS-SLS) waivers.

D. Authorized Representative means an individual designated by a Client or by the parent or guardian of the Client, if appropriate, to assist the Client 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) as defined in Section 8.510.1.

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

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

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

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

I. Certification means the process by which an agency is approved by the Department to provide case management which includes the submission and approval of a Medicaid Provider Agreement along with submission of verification that the agency meets the qualifications as set forth in Section 8.519.

J. Client means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

K. Client Representative means a person who is designated by the Client to act on the Client's behalf. A Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

L. Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

M. Comprehensive Assessment means an initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support.

N. Conflict-Free Case Management means, pursuant to 42 CFR § 441.301(c)(1)(vi), case management services provided to a Client enrolled in a Home and Community-Based Services waiver that are provided by a Case Management Agency that is not the same agency that provides services and supports to that person.

O. Corrective Action Plan means a written plan by the CMA, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

P. Critical Incident means incidents or allegations involving Clients receiving services to include mistreatment, abuse, neglect, exploitation, illness/injury, death, damage to consumer's property/theft, medication management issues, criminal activity, unsafe housing/displacement, and missing persons.

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

R. Developmental Delay means as defined in Section 8.600.4.

S. Developmental Disability means as defined in Section 8.600.4.

T. Executive Director means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

U. Financial Eligibility means the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources, if applicable.

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

W. Guardian ad litem or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in article 33 of title 22, C.R.S.

X. Home and Community-based Services (HCBS) waivers means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires an institutional Level of Care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

Y. Incident means an injury to a person receiving services; lost or missing persons receiving services; medical emergencies involving persons receiving services; hospitalizations of persons receiving services; death of persons receiving services; errors in medication administration; incidents or reports of actions by persons receiving services that are unusual and require review; allegations of abuse, mistreatment, neglect, or exploitation; use of safety control procedures; use of emergency control procedures; and stolen personal property belonging to a person receiving services.

Z. Information Management System (IMS) means an automated data management system approved by the Department to enter case management information for each individual seeking or receiving long-term services as well as to compile and generate standardized or custom summary reports.

AA. Interdisciplinary Team (IDT) means a group of people convened by a certified Case Management Agency that includes the person receiving services, the parent or guardian of a minor, guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as chosen by the person receiving services, who are assembled to work in a cooperative manner to develop or review the Service Plan.

BB. Legally Responsible Persons means the parent of a minor child, or the Client's spouse,

CC. Level of Care Determination means determining eligibility of an individual for a Long-Term Services and Supports (LTSS) program and determined by a Community Centered Board or Single Entry Point Agency.

DD. Level of Care Evaluation means a comprehensive evaluation with the individual seeking services and others chosen by the individual to participate and an evaluation by the Case Manager utilizing the Department prescribed tool, with supporting diagnostic information from the Client's medical provider, and to determine the Client's level of functioning for admission or continued stay in certain Long-Term Services and Supports (LTSS) programs.

EE. Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

FF. Medicaid Eligible means an applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

GG. Organized Health Care Delivery System (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

HH. Parent means the biological or adoptive parent.

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

JJ. Prior Authorization Requests (PAR) means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

KK. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to certify Level of Care.

LL. Provider for the purpose of this section means any person, group or entity approved to render services or provide items to a Client enrolled in an HCBS waiver program.

MM. Regional Center means a facility or program operated directly by the Department of Human Services which provides services and supports to Clients with intellectual and developmental disabilities.

NN. Retrospective Review means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the Service Plan and that the Case Management Agency complied with the requirements set forth in statute, waiver, and regulations.

OO. Service Plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.

PP. Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

QQ. Supports Intensity Scale (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with intellectual and developmental disabilities.

RR. Support Level means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

SS. Support Planning means the process of working with an individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate services providers based on the individual's assessment and knowledge of the individual and available community resources. Support planning includes informing the individual seeking or receiving services of his or her rights and responsibilities.

TT. Targeted Case Management (TCM) means case management services provided to Clients enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

UU. Waiver Services means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid state plan services.

**8.519.2 Case Management Agency Qualifications**

8.519.2.A. A CMA must meet the following qualifications:

1. Have a physical location in Colorado and provide all required case management activities for the counties in which the agency elects to serve.

2. Be a public or private not for profit or for profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services pursuant to Section 25.5-10-209.5, C.R.S. Case management agencies that are private not for profit must have certification from the state of Colorado or a letter from the Department of the Treasury, internal revenue service classifying the agency as a private not for profit agency.

3. Provide proof that the agency staff meets all Case Manager qualifications.

4. As an agency, have a minimum of two years of agency experience in assisting high-risk, low income individuals, to obtain medical, social, educational and/or other services. Case Management Agencies who were previously affiliated with an agency providing HCBS case management prior to August 30, 2019 are exempt from this requirement.

5.. Demonstrate the agency does not have any fiduciary relationship with an agency who provides HCBS waiver services. Agencies providing HCBS case management prior to August 30, 2019 are exempt from this requirement.

6.. Provide case management to Clients who select the agency as long as the Client reside in the county for which the agency has elected to provide case management services

7. Possess the administrative capacity to deliver case management services in accordance with state and federal requirements.

8. Have established community referral systems and demonstrate linkages and the ability to make community referrals for services with other agencies.

9. Demonstrate ability to meet all state and federal requirements governing the participation of case management agencies in the state Medicaid program, including but not limited to the ability to meet state and federal requirements for documentation, billing and auditing.

10. Have one-month reserve financial capacity to maintain operations. HCBS case management agencies providing case management services in Colorado prior to August 30,2019 are exempt from this requirement.

11. Demonstrate that the agency has financial reserves for one month of expenditures to cover costs associated with the number of Clients expected through their catchment area, including reserves to cover salaries and costs for Case Managers, and Clients. All agencies are required to submit an audited financial statement to the Department for review annually. Agencies providing HCBS case management services in Colorado prior to August 30, 2019 are exempt from this one-month financial requirement.

12. Possess and maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department’s minimum requirements.

13. Shall not be an approved provider agency providing direct services to individuals who are enrolled in HCBS waivers. Agencies providing HCBS case management prior to August 30, 2019 are exempt from this requirement

**8.519.3 Functions of all Case Management Agencies**

8.519.3.A Case Management Agencies must:

1. Maintain sufficient documentation of case management activities performed and to support claims.

2. Not provide guardianship services for any Client enrolled in an HCBS waiver.

3. Maintain, or have access to, information about public and private state and local services, supports and resources and shall make such information available to the Client and/or persons inquiring upon their behalf.

4. Be separate from the delivery of services and supports for the same individual, unless otherwise approved as an exception by the Centers for Medicare and Medicaid services (CMS) in the approved waiver application. Agencies providing HCBS case management services prior to August 30, 2019 shall comply with the timelines set forth at Sections 25.5-10-211.5(3)(f)-(g), C.R.S.

5. Assign one (1) primary person who ensures case management services are provided on behalf of the Client across all programs, professionals within the agency. Reasonable efforts shall be made to include the Client's preference in this assignment.

6. Ensure that services are available on Business Days.

7. Maintain records for seven (7) years after the date a Client discharges from a waiver program, including all documents, records, communications, notes and other materials related to services provided and work performed.

8. Possess appropriate financial management capacity and systems to document and track services and costs in accordance with state and federal requirements.

9. Maintain and update records of persons determined to be eligible for services and supports and who are receiving case management services in accordance with the Departments requirements.

10. Establish and maintain working relationships with community-based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the Clients' needs.

11. Have a system for recruiting, hiring, evaluating, and terminating employees, and maintain employment policies and practices that comply with federal and state laws.

12. Maintain current written job descriptions for all positions.

13. Maintain a website that at a minimum contains contact information for the agency, the ability for electronic communication, hours of operation, available resources, program options, and services provided.

14. Ensure staff have access to statutes and regulations relevant to the provision of authorized services.

15. Provide case management services for Clients without discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression or disability.

16. Provide information and reports as required by the Department including, but not limited to, data and records necessary for the Department to conduct operations.

17. Allow access by authorized personnel of the Department, or its contractors, for the purpose of reviewing documents and systems relevant to the provision of case management services and supports funded by the Department and shall cooperate with the Department in the evaluation of such services and supports.

18. If the Case Management Agency is unable to continue providing case management services, the agency must submit a written notice to the Department at least 90 days prior to terminating services. The written notice shall include the effective date of termination.

19. As part of the application process to be an approved Case Management Agency, the agency shall submit a Closeout Plan that describes all requirements, steps, timelines, and milestones necessary to fully transition the services provided by the agency to another Case Management Agency. The Closeout Plan shall designate an individual to act as a closeout coordinator who will ensure that all requirements, steps, timelines, and milestones contained in the Closeout Plan are completed and work with the Department and any other agency to minimize the impact of the transition on Clients and the Department. The Closeout Plan shall include, but is not limited to, all of the following:

    a. Notification and communication of agency closure to the Department, Clients and providers;

    b. Transfer of Clients;

    c. Transfer of documentation to include all electronic and physical documentation;

    d Transfer of all Client records through the Department Case Management System; and

    e. Transfer of Case Management Services.

20. Case Management Agencies are responsible for ensuring persons who are employed by the agency meet the requirement of these regulations

21. Maintain verification of Case Managers who are employed meet minimum requirements and qualifications

**8.519.4 Staffing**

8.519.4.A. The case management agency shall provide staff for the following functions: receptionist/clerical, administrative/supervisory, and case management.

1. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, and assisting case management agency staff with clerical duties.

2. The administrative/supervisory function shall include, but not be limited to, supervision of staff, training and development of agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, resource development, marketing liaison with the Department, and, as needed, providing case management services in lieu of the case manager.

**8.519.5. Qualifications of Case Managers**

8.519.5.A. All Home and Community-Based (HCBS) case managers must be employed by a certified Case Management Agency.

1. CMAs must maintain verification that employed case managers meet the qualifications set forth in these regulations.

8.519.5.B. minimum qualifications for HCBS Case Managers hired on or after October 8th, 2021 are:

1. A bachelor's degree; or

2. Five (5) years of relevant experience in the field of LTSS, which includes Developmental Disabilities; or

3. Some combination of education and relevant experience appropriate to the requirements of the position.

4. Relevant experience is defined as:

a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and,

b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.

8.519.5.C. Case Managers may not:

1. Be related by blood or marriage to the Client.

2. Be related by blood or marriage to any paid caregiver of the Client.

3. Be financially responsible for the Client.

4. Be the Client's legal guardian, authorized representative, or be empowered to make decisions on the Client's behalf through a power of attorney.

5. Be a provider for the Client, have an interest in, or be employed by a provider for the same Client. Case Managers employed by a Case Management Agency that is operating under an exception approved by the Centers for Medicare and Medicaid Services (CMS) in the approved waiver application are exempt from this requirement.

8.519.5.D. Case Managers must complete the Department prescribed attestation form.

8.519.5.E. Case Managers must complete and document the following trainings within 120 days from the date of hire and prior to providing case management services independently:

1. Department prescribed assessment tool;
2. Service plan development and revision;
3. Referral for services, to include Medicaid and non-Medicaid;
4. Monitoring;
5. Case documentation;
6. Level of Care determination process;
7. Notices and appeals;
8. Incident and critical incident reporting;
9. Waiver requirements and services;
10. Person-centered approaches to planning and practice;
11. Interviewing and assessment skills; and
12. Regulations and state statutes for the LTSS program.
13. Department IMS Documentation
14. Mandatory Reporting
15. Participant Directed Training
16. Disability and Cultural Competency
17. Any Case Management training required by contract

8.519.5.F. Case Managers must demonstrate and document competency in the following areas:

1. Knowledge and experience working with populations served by the Case Management Agency;
2. Knowledge of the statutes, regulations, policies and procedures regarding public assistance programs and the American with Disabilities Act;
3. Knowledge of LTSS and other community resources;
4. Negotiation, conflict resolution, intervention, cultural and linguistic training, disability cultural competency, and interpersonal communication skills; and
5. Knowledge of consumer direction philosophy and programs.

8.519.5.G. Case Managers shall attend any mandatory training required by the Department.

8.519.5.H. Case Manager supervisors shall meet the minimum requirements for education and/or experience for Case Managers and shall have one year of competency in pertinent case management knowledge and skills.

8.519.5.I. Background checks.

1. Prior to employment, all case management staff must have the following minimal background checks and screenings:

   a. Criminal;

   b. Medicaid or other federal health programs exclusion list;

   c. Sex offender registry; and

   d. Adult protective services data system.

2. Background checks must be repeated at minimum every five (5) years with the exception of the adult protective services data system.

3. Proof of checks and screenings must be maintained and made available.

**8.519.6 Case Management Agency selection- To be implemented no later than January 1, 2021**

8.519.6.A. Clients have the ability to change their Case Management Agency at any time, with the exception of initial enrollment into a waiver.

1. Clients must remain with the initial chosen Case Management Agency for at least 60 calendar days or until the service plan is developed, whichever is sooner.

8.519.6.B. At the time the Client has met all eligibility requirements for an HCBS waiver the Community Centered Board, shall within two (2) business days send a referral to the Department's contractor to assist the Client in selecting a CMA.

1. The Department's contractor shall contact the Client within two (2) business days from the date of referral from the CCB.

   a. The Client, or the Client's guardian, shall inform the Department's contractor of their choice of Case Management Agency.

   b. The Department's contractor shall assist the Client in selecting a CMA when necessary, which may include, but is not limited to:

      i. Providing a list of qualified CMAs.

      ii. Providing the Department's webpage address and information on how to search for a CMA.

      iii. Providing information regarding the qualified CMAs based on the Client's preferences.

      iv. In addition to other assistance as requested or needed by the Client.

2. The Department's contractor shall notify the selected CMA within two (2) business days from the date of selection by the Client.

a. The Departments contractor shall send a letter to the Client with the following information:

i. The selected CMA, address and contact information;

ii. Information about the Client's right to choose a CMA; and

iii. Contact information for the Department's contactor.

3. The selected CMA shall contact the Client within two (2) business days from notification of selection to confirm the choice and schedule a meeting to develop the Service Plan.

8.519.6.C Case Management Agency transfer

1 When a Client wishes to change their CMA, the Client must notify the current CMA or contact the Department's contractor directly.

a. The CMA shall notify the Department's contractor that the Client would like to change their CMA if the Client did not notify the contractor directly.

b The Department's contractor shall contact the Client within two (2) business days from the date of referral from the CMA or notification from the Client.

i. When the Client seeking case management services and/or their guardian, as appropriate, knows which approved CMA the Client wishes to select, the Client will inform the Department's contractor of their choice.

ii. When the Client seeking case management services and/or their guardian, as appropriate, does not know which approved CMA the Client wishes to select, the Department's contractor shall assist the Client in the selection of a CMA which may include, but is not limited to:

1. Providing a list of qualified CMAs.

2. Providing the Department's webpage address and information on how to search for a CMA.

3. Providing information regarding the qualified CMAs based on the Client's preferences.

4. Other assistance as requested or needed by the Client

iii. The Department's contractor shall notify the selected CMA within two (2) business days from the date of selection by the Client. The Department's contractor shall also send a letter to the Client with the following information:

1. The selected CMA;

2. Contact information for the CMA;

3. Information about the right to choose a CMA; and

4. Contact information for the Department's contractor.

iv. The selected CMA shall contact the Client within two (2) business days from notification of selection to confirm the choice and review service plan and any changes necessitated by the transfer.

v. The transferring CMA shall continue to provide case management services until the new CMA has been assigned in the Department's prescribed system and contacted the Client in accordance with 8.519.6.B(3).

**8.519.7 Functions of Case Management Agencies for HCBS-CES, HCBS-CHRP, HCBS-DD, and HCBS-SLS**

8.519.7.A. Case Management Agencies shall comply with the regulations at Sections 8.500 et seq., 8.503 et seq., 8.600 et seq. and 8.760 et seq.

8.519.7.B. The Case Management Agency chosen by the Client is responsible for providing case management services.

8.519.7.C. Case Management Agencies shall establish agency written procedures sufficient to execute case management services according to the provisions of these regulations. Such procedures shall include, but are not limited to:

1. Comprehensive assessment and periodic reassessment of a Client's needs;

2. Development and periodic revision of Client Service Plans;

3. Referral and related activities;

4. Monitoring;

5, The authorization and purchase of services and supports;

6. Services and support coordination;

7. Any safeguards necessary to prevent conflict of interest between case management and direct services provision; and

8. Denial and discontinuation of services.

8.519.7.D. Case Management Agencies shall have written procedures concerning the exercise and protection of Client rights pursuant to Sections 25.5-10-218 through 231, C.R.S.

8.519.7.E. Case Management Agencies shall have written procedures for Clients to dispute agency decisions, adverse actions, or actions of the agency's employees or contractors. Disputes may be filed by the Client, or parent of a minor Client, the Client's guardian, advocate, or the Client's authorized representative if within the scope of his/her duties. Agency procedures shall meet the requirements of Section 8.605.5. The agency shall offer and provide interpretation or translation services in languages other than English, and through such other modes of communication as may be necessary.

**8.519.8 Compliance**

8.519.8.A. Pursuant to Section 25.5-10-208 (4), C.R.S., upon a determination by the executive director or designee that services and supports have not been provided in accordance with the program or financial administration standards contained in these rules, the executive director or designee may reduce, suspend, or withhold payment to a Case Management Agency from which the Department purchases services or supports directly.

8.519.8.B. Prior to initiating action to reduce, suspend, or withhold payment to a Case Management Agency for failure to comply with Department regulations, the executive director or designee shall provide written notice which must specify the reasons for the action and the actions necessary to achieve compliance.

8.519.8.C. The executive director or designees may revoke the Case Management Agency's certification upon a finding that the agency is in violation of provisions of Section 25.5-10-209.5, C.R.S, other state or federal laws, or these rules.

**8.519.9 Payment for Case Management Services**

8.519.9.A. Targeted case management services are only reimbursed for Clients enrolled in the HCBS-CES, HCBS-CHRP, HCBS-DD, HCBS-SLS waivers, and only if the services are in compliance with the requirements set forth at Section 8.760 et seq.

**8.519.10 Case Management Payment Liability**

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

B. If the Case Management Agency causes a Client enrolled in HCBS waiver services to have a break in payment authorization, the agency will ensure that all services continue and will be solely financially responsible for any losses incurred by service providers until payment authorization is reinstated.

**8.519.11 Case Management Services**

8.519.11.A. Clients must be determined eligible for an HCBS waiver specific for individuals with Intellectual or Developmental Disabilities by a Community Centered Board prior to receiving case management services.

8.519.11.B. Case management services include the following:

1. Assessment: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support. Assessment activities include:

    a. Obtaining Client history;

    b. Identifying the Client's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers and educators, as necessary to form a complete assessment of the Client.

2. Service plan development and revision occurs no less than annually or as a warranted by the Client's needs or change in condition, at a time and location convenient for the Client with the Client and others chosen by the Client. The Case Manager shall complete and review a service plan for each Client enrolled in the HCBS-CES, HCBS-DD, and HCBS-SLS waivers.

    a. The service plan at minimum shall:

        i. Identify needs, personal goals, preferences, unique strengths, abilities, desires, health and safety, and risk factors;

        ii. Be in accordance with the Department's regulations, policies and procedures;

        iii. Identify the specific services and supports appropriate to meet the needs of the eligible Client, and family, as applicable;

        iv. Document decisions made through the service planning process including, but not limited to, rights suspension/modifications, the existence of appropriate services and supports and the actions necessary for the plan to be achieved;

        v. Document the authorized services and supports funded by the Department and the date authorized services begin or the projected date of initiation;

        vi. Identify a contingency plan for how necessary supports will be provided in the event that the Client's family, caregiver, or direct HCBS waiver provider is unavailable due to an emergency situation or unforeseen circumstances;

        vii. Have a listing of the service plan participants and their relationship to the Client;

        viii. Contain a statement of agreement with the plan signed, physical or digital signature, by the Client or other such person legally authorized to sign on the Client's behalf; and

        ix. Be in effect for a period not to exceed one year without review and be reviewed and amended as determined by the Case Manager, Client, and others as applicable.

    b. The service plan shall document that the Client has been offered a choice:

        i. In the Home and Community-based Services or institutional care,

        ii. Of waiver services, including service delivery options, and

        iii. Of qualified providers.

    c. The service plan shall contain documentation that the Client is aware of the conflict of interest in situations where the Case Management Agency is the only agency able to provide direct HCBS waiver services, as approved in the waiver application, and that the Client has been provided a complaint and grievance procedure.

d. The service plan development shall occur at times and locations chosen by the Client to include but not limited to the Client's place of residence, place of service, or other appropriate setting as determined by the Client's needs or preferences.

e. Others chosen by the Client shall be provided notification at least ten (10) days prior to the service plan meeting, if possible.

f. Copies of the service plan shall be disseminated to all persons and providers involved in implementing the service plan including the Client, their legal guardian, authorized representative and parent(s) of a minor, and others as applicable. If requested, copies shall be made available prior to the provision of services or supports, or within a reasonable period of time not to exceed thirty (30) days from the development of the service plan and in accordance with these rules;

3. Referral: the Case Manager shall assist Clients to obtain needed HCBS waiver services or other programs and services, to include non-Medicaid services, which include making referrals to providers, scheduling appointments, and assisting with access to transportation as needed or requested by the Client.

4. Monitoring: the Case Manager shall ensure that Clients receive services in accordance with their Service Plan and monitor the quality of the services and supports provided to the Clients.

a. The frequency and level of monitoring shall meet the requirements of the waiver in which the Client is enrolled. At a minimum, monitoring shall occur at least once per quarter, face-to-face, in a place where services are delivered, and review the following for each Client:

i. The delivery and quality of services and supports identified in the service plan including ensuring that services are delivered in accordance with the scope, frequency, and duration documented in the service plan;

ii. The health, safety and welfare of Clients, including the provider agencies' procedures to address the Client's needs;

iii. The satisfaction with services and choice in providers;

iv. Services are being delivered in a way that promote a Client's ability to engage in self-determination, self- representation and self-advocacy;

v. Concerns or issues as they relate to provider agencies. The Case Manager shall contact the provider agency to coordinate, arrange, or adjust services to address and resolve quality issues or concerns;

vi. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or misutilization of any public assistance benefit and shall cooperate with the appropriate agency in any subsequent recovery process.

b. Upon Department approval, monitoring 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 Client (e.g. natural disaster, pandemic, etc.).

5. Remediation: the Case Manager shall identify and implement strategies to prevent and resolve problems with the delivery of services and supports.

**8.519.12 Case Documentation**

8.519.12.A. The Case Management Agency shall complete and maintain all required records in the state approved IMS and shall maintain individual case records at the agency level for any additional documents associated with the individual enrolled in a HCBS waiver.

1. The case records shall include:

a. Identifying information, including the Client's state identification (Medicaid) number, date of birth (DOB) social security number (SSN), address and phone number;

b. Department required forms specific to the program in which the Client is enrolled; and

c. Documentation of all case management activity.

2. Case management documentation shall meet all of the following standards:

a. Be objective and understandable;

b. Occur at the time of the activity or no later than five (5) business days from the time of the activity;

c. Dated according to the date of the activity, including the year;

d. Entered into the Department's IMS;

e. Identify the person creating the documentation;

f. Entries must be concise and include all pertinent information;

g. Information must be kept together, in a logical organized sequence, for easy access and review;

h. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact or is a someone's judgement or conclusion;

i. All persons and agencies referenced in the documentation must be identified by name and by relationship to the individual;

j. All forms prescribed by the Department shall be completely and accurately filled out by the Case Manager; and,

k. If the Case Manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the case management agency's control, the circumstances shall be documented in the case record.

3. These circumstances shall be taken into consideration when monitoring the Case Management Agency's performance.

**8.519.13 Choice of provider agency for authorized HCBS waiver services**

8.519.13.A. Clients and/or their guardians and authorized representatives, as appropriate, who enroll in HCBS waiver services shall have the freedom to choose from qualified provider agencies in accordance with Section 8.603, as applicable.

8.519.13.B. Case Management Agencies shall provide Clients, and/or their guardian, and authorized representatives, as appropriate, informed choice on all provider agencies qualified to provide the authorized HCBS waiver services.

1. When the Client or guardian, or authorized representative when applicable, knows which qualified provider agency(ies) they want to provide the authorized HCBS waiver service(s), the Client shall inform the Case Manager of their choice.

a. The Case Manager shall contact the selected provider agency(ies) regarding the Client's needs, the services authorized, and the scope, frequency, and duration of services.

b. If the provider agency(ies) are willing to provide the authorized HCBS waiver service(s), the Case Manager shall create the Prior Authorization Request in accordance with Section 8.519.14.

c. If the provider agency(ies) are not willing to provide the authorized HCBS waiver service(s), the Case Manager shall inform the Client and discuss options for additional provider selection as outlined in Section 8.519.13.B(2).

2. If the Client or guardian (as appropriate) does not know which provider agency(ies) the Client wants to select, the Case Manager shall provide informed choice to the Client which may include, but is not limited to:

a. Providing a list of qualified provider agencies;

b. Providing the Department's webpage address and information on how to search for a qualified provider agency;

c. Providing resources for accessing information about provider agency quality, such as survey information, that is available to the public;

d. Providing information regarding qualified provider agencies based on the Client's preferences;

e. Contacting all qualified provider agencies, with information regarding the requested and authorized service(s) including the scope, frequency, level of support necessary, and duration of the services for the purpose of receiving responses from qualified service agencies who can serve the Client to not include Support Level information unless requested by the Client family and/or guardian; or

f. In addition to other assistance as requested or needed by the Client.

3. The case manager shall document the Client's choice of provider agency(ies) and the method by which the choice was made in the Service Plan and in the Department's prescribed system.

4. Case Managers shall contact all requested providers within five (5) business days of the Client's selection.

**8.519.14 Prior Authorization Requests (PAR)**

8.519.14.A. The Case Manager shall submit a PAR in compliance with all applicable regulations and ensure requested services are:

1. Consistent with the Client's documented medical condition and needs assessment;

2. Adequate in amount, frequency, scope and duration in order to meet the Client's needs and within the limitations set forth in the current federally approved waiver; and

3. Not duplicative of another service, including but not limited to services provided through:

a. Medicaid state plan benefits,

b. Third party resources,

c. Natural supports,

d. Charitable organizations, or

e. Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to Section 8.058.4.

**8.519.15 Regional Center Referral Process**

8.519.15.A. Referrals to the Regional Centers shall comply with the Regional Centers admission policy located on the Colorado Department of Human Services website.

**8.519.16 Critical Incident Reporting**

8.519.16.A. Case Management Agencies shall have a written policy and procedure for the recording, reviewing, and reporting of critical incidents. Critical incident reporting is required when the following occurs:

1. Injury/Illness;

2. Missing Person;

3. Criminal Activity;

4. Unsafe Housing/Displacement;

5. Death;

6. Medication Management Issues;

7. Other High Risk Issues ;

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

9. Damage to Consumer's Property/Theft.

8.519.16.B. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the agency administrator or designee, Case Management Agency, and to the CCB

1. Case Managers shall comply with mandatory reporting requirements set forth at Section 18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102, C.R.S.

8.519.16.C. Case Managers shall report critical incidents in the State-Approved IMS within 24 hours of notification. Each report must include:

a. Incident type

i. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, C.R.S, Section 26-3.1-101, C.R.S, Section 16-22-102 (9) C.R.S, and Section 25.5-10-202 C.R.S.

ii. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, other high-risk issues.

b. Date and time of incident;

c. Location of incident, including name of facility, if applicable;

d. Individuals involved.

e. Description of incident, and

f. Resolution of incident, if applicable.

g. Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.

8.519.16.D. Incident reports submitted to by a provider to the CCB or, Case Management Agency will be reviewed by the case manager, documented into the state IMS and entered as a critical incident if the incident meets critical incident reporting criteria. Incident reports are to be made available to the Department upon request.

**8.519.17 Client Responsibilities**

8.519.17.A. A Client, when provided with appropriate and necessary accommodations, or guardian is responsible to:

1. Provide accurate information regarding the Client's ability to complete activities of daily living;

2. Assist in promoting the Client's independence;

3. Cooperate in the determination of financial eligibility for Medicaid;

4. Notify the Case Manager within thirty (30) days after:

   a. Changes in the Client's support system, medical, physical or psychological condition, or living situation including any hospitalizations, emergency room admissions, placement in a nursing home or Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID)

   b. The Client has not received an HCBS waiver service during one (1) calendar month;

   c. Changes in the Client's care needs;

   d. Problems with receiving HCBS waiver services for which the Client would like the Case Manager's assistance to resolve; and

   e. Changes that may affect Medicaid financial eligibility, including promptly reporting changes in income or assets;

   f. Client will notify the Case Manager when withdrawing from services.

5. Cooperate with Case Management Agency requirements for the functions of case management outlined in Section 8.519 et seq.

**8.519.18 Use of an Authorized Representative**

8.519.18.A. Clients who are eligible for services and supports, the parent or guardian of a minor, or legal guardian of an adult, shall be informed at the time of enrollment and at each annual review of the service plan that they may designate an authorized representative. The designation of an authorized representative must occur with informed consent of the Client, or the parent or guardian of a minor, or legal guardian of an adult.

8.519.18.B. A designation of an authorized representative shall be in writing and specify the extent of the authorized representative's involvement in assisting the Client receiving services, in acquiring or utilizing services or supports available, and in safeguarding the Client's rights.

8.519.18.C. The written designation of an authorized representative shall be maintained in the Client's record and shall be reviewed annually.

8.519.18.D. The Client may withdraw their designation of an authorized representative at any time and must notify the Case Manager of the withdrawal.

**8.519.19 Petitions for Declaratory Orders**

8.519.19.A. Disposition of petitions for declaratory orders

1. The executive director of the Department or designee may entertain petitions for declaratory orders in accordance with Section 24-4-105 (11), C.R.S., when a controversy or uncertainty exists as to the applicability of any statutory or regulation of the Department to a party. A petition may be filled when a process for resolving the controversy or uncertainty is not otherwise provided in these rules.

8.519.19.B. Any petition filled pursuant to this rule shall set forth the following:

1. The name and address of the petitioner;

2. The statute, rule or order to which the petition relates;

3. A concise statement of all of the facts necessary to show the nature of the controversy of uncertainty; and.

4. All parties directly involved in the subject matter of the petition known to the petitioner.

8.519.19.C. If the executive director or designee decides to rule on the petition, the following procedure shall apply:

1. The executive director or designee shall provide notice of the petition and an opportunity to respond to the petition to all parties noted by the petitioner or otherwise known to the Department to be directly interested in the petition.

2. The executive director or designee may rule upon the petition based solely upon the facts presented in the petition and response. In such a case any ruling of the Department will apply only to the extent of the facts presented in the petition and the response.

3. The executive director or designee may request the petitioner or any involved party to submit additional information, or file a written brief, memorandum, or statement of position.

4. The executive director or designee may rule upon the petition without a hearing or may set the petition for hearing, upon due notice to all parties to obtain additional facts or information.

5. The ruling of the Department shall be Final Agency Action subject to judicial review.

**8.519.20 Grievance/Complaint process**

8.519.20.A. Case Management Agencies shall have procedures setting forth a process for the timely resolution of grievances or complaints. Use of the grievance procedure shall not prejudice the future provision of appropriate services or supports.

8.519.20.B. The grievance procedure shall be provided, orally and in writing, to all Clients receiving services, the parents of a minor, guardian and/or authorized representative, as applicable, at the time of submission and at any time that changes to the procedure occur.

8.519.20.C. The grievance procedure shall, at a minimum, including the following:

1. Contact information for a person within the CMA who will receive grievances.

2. Identification of support person(s) who can assist the Client in submitting a grievance.

3. An opportunity to find a mutually acceptable solution. This could include the use of mediation if both parties voluntarily agree.

4. Timelines for resolving the grievance.

5. Consideration by the agency director or designee if the grievance cannot be resolved at a lower level.

6. Assurances that no Client shall be coerced, intimidated, threatened or retaliated against because the Client has exercised his or her right to file a grievance or has participated in the grievance process.

**8.519.21 Termination from services and supports**

8.519.21.A. A Client shall be terminated from services and supports if the CCB or Case Management Agency determines that the Client no longer meets the eligibility criteria.

8.519.21.B. A Client shall be discontinued from a service or support upon determination, made pursuant to the service planning process, that the services or supports are no longer appropriate or necessary to meet the Client's needs.

8.519.21.C. A Client receiving services may notify a service agency, verbally or in writing, that he or she no longer wishes to receive services from the provider agency. If the Client is a minor, has a legal guardian, authorized representative or is under court jurisdiction, the Client's parent(s), guardian or authorized representative shall be notified immediately after the Client notifies the service agency of the desire to discontinue services. The parent(s) of a minor or legal guardian shall be provided the option to exercise their decision-making authority on behalf of the Client receiving service, unless otherwise ordered by a court.

**8.519.22 Notice and Appeal Rights**

8.519.22.A. The Case Management Agency shall provide the long-term care notice of action form to Clients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq*, when:

1. An adverse action occurs that affects the provision of the Client's waiver services, or:

8.519.22.B. The Case Management Agency shall notify all providers in the Client's service plan within one (1) business day of the adverse action.

1. The Case Management Agency shall notify the county Department of Human/Social services income maintenance technician within ten (10) business days of an adverse action that may affect financial eligibility for HCBS waiver services.

8.519.22.C. The applicant or Client shall be provided a notice of adverse action if the applicant or Client is determined to be ineligible as set forth in the waiver specific Client eligibility criteria and the following:

1. The Client cannot be served safely within the cost containment as identified in the HCBS waiver;

2. The Client is placed in an institution for treatment for more than thirty (30) consecutive days;

3. The Client is detained or resides in a correctional facility; or

4. The Client enters an institute for mental health for more than thirty (30) consecutive days.

8.519.22.D. The Client shall be notified, pursuant to Section 8.057.2.A., when the following results in an adverse action that does not relate to waiver Client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the needs assessment;

2. A service plan or waiver service exceeds the limits set forth in the federally approved waiver;

3. The Client is being terminated from HCBS due to a failure to attend a Level of Care assessment appointment after three (3) attempts to schedule by the Case Manager within a thirty (30) day consecutive period.

4. The Client is being terminated from HCBS due to a failure to attend a Service Plan appointment after three (3) attempts to schedule by the Case Manager within a thirty (30) day consecutive period.

5. The Client enrolls in a different LTSS program, or

6. Benefits are terminated because the Client moves out of state.

   A. A Client who leaves the state on a temporary basis, with intent to return to Colorado, pursuant to Section 8.100.3.B.4, shall not be terminated unless one or more of the other Client eligibility criteria are no longer met.

7. The Client voluntarily withdraws from the waiver. The Client shall be terminated from the waiver effective upon the day after the date on which the Client's request is documented.

   A. The Case Manager shall review with the Client their decision to voluntarily withdraw from the waiver. The Case Manager shall not send a notice of action, upon confirmation of withdraw.

8.519.22.E. The case management agency shall not send the LTC notice of action form when the basis for termination is death of the Client, but shall document the event in the Client record. The date of action shall be the day after the date of death.

8.519.22.F. The case management agency shall appear and defend their decision at the Office of Administrative Courts when the case management agency has made a denial or adverse action against a Client.

1. When the Office of Administrative Courts rules in favor of the appellant, the Case Management Agency shall file exceptions when appropriate.

**8.519.23 Retrospective review process**

8.519.23.A. Services provided to a Client are subject to a retrospective review which includes but is not limited to a performance and quality review by the Department. The retrospective review shall ensure that services:

1. Identified in the service plan are based on the Client's assessed needs;

2. Have been requested and approved prior to the delivery of services;

3. Provided to a Client are in accordance with the service plan, and;

4. Provided within the specified HCBS waiver service definition in the federally approved HCBS waiver.

8.519.23.B When the retrospective review identifies areas of noncompliance, the case management agency shall be required to submit a corrective action plan that is monitored for completion by the Department.

8.519;23.C. The inability of the case management agency to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.519.23.D. When the provider has received reimbursement for services and the review by the Department identifies that it is not in compliance with requirements, the amount identified is subject to recovery pursuant to Section 8.076.

**8.519.27 Transition Coordination Services**

**8.519.27.A Definitions**

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

2. Community risk level means the potential for a Client living in a community-based arrangement to require emergency services, to be admitted to a hospital, skilled nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities, be evicted from their home or be involved with law enforcement due to identified risk factors.

3. Post-transition monitoring means the activities that occur after a Client has successfully transitioned into the community and is a recipient of home-and community-based services.

4. Pre-Transition Coordination means activities that occur before a Client has transitioned into the community to prepare the Client for success in community living and integration.

5. Risk factors means factors that include but are not limited to health, safety, environmental, community integration, service interruption, inadequate support systems and substance abuse that may contribute to an individual's community risk level and potential for readmission to an institution.

6. Risk mitigation plan means the document that records the risk mitigation planning process. Risk mitigation plans are used to conduct post-discharge monitoring of effectiveness of risk prevention strategies; to document identification of additional risk factors, and to revise risk incident response plans.

7. Risk mitigation planning means the process of identifying risk factors, developing options and actions to enhance opportunities and prevent adverse consequences that would result if risk is not managed and identifying planned actions to take in response to an adverse consequence should a risk be realized.

8. Service plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department regulations.

9. Transition Coordination means support provided to a Client who is transitioning from a skilled nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities, or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition.

10. Transition assessment means the process of capturing a comprehensive understanding of the Client's health conditions, functional needs, transition needs, behavioral concerns, social and cultural considerations, educational interests, risks and other areas important to community integration and transition to a home and community-based setting.

11. Transition Coordination agency (TCA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide Transition Coordination pursuant to a provider participation agreement with the Department.

12. Transition coordinator (TC) means a person who provides Transition Coordination services and meets all regulatory requirements for a transition coordinator.

13. Transition options team (TOT) means the group of people involved in supporting and implementing the transition, to include the person receiving services, the transition coordinator, the family, guardian or authorized representative, the home- and community-based services case manager, and others chosen by the individual receiving services as being valuable to participate in the transition process.

14. Transition period means the period of time in which the Client receives Transition Coordination for the purpose of successful integration into community living. A transition period is complete when the Client has successfully established community residence and is no longer in need of Transition Coordination based on the risk mitigation plan.

15. Transition plan means the written document that identifies person-centered goals, assessed needs, and the choices and preferences of services and supports to address the identified goals and needs; appropriate services and additional community supports; outlines the process and identifies responsibilities of transition options team members; details a risk mitigation plan; and establishes a timeline that will support an individual in transitioning to a community setting of their choosing.

16. Transition planning means development of a transition plan, risk mitigation plan and transition plan in coordination with the transition options team.

**8.519.27.B Qualifications of Transition Coordination Agencies**

In order to be approved as a transition coordination agency, the agency shall meet all of the following qualifications:

Have a physical location in Colorado.

Be a public or private not for profit or for profit agency.

Demonstrate proof the agency has employed staff that meet transition coordinator qualifications.

Have a minimum of two years of agency experience in assisting high-risk, low income individuals to obtain medical, social, education and/or other services. Transition coordination agencies providing transition coordination in Colorado prior to December 31, 2018 are exempt from this requirement.

Provide transition coordination to clients who select the agency and also reside in the county/counties for which the agency has elected to provide services.

Possess the administrative capacity to deliver transition coordination.

Have established community referral systems and demonstrate linkages and referral ability to make community referrals for services with other agencies.

Demonstrate ability to meet all applicable requirements contained within Sections 8.125, 8.130, 8.519.27, 8.763, the Medicaid State Plan and the provider participation agreement.

Have one month reserved financial capacity or access to at least one month of average monthly expenses.

Financial reserves shall match one month of expenditures associated to the number of clients expected through that catchment area and provide stability for transition coordinators, clients and service providers.

All agencies are required to submit an audited financial statement or equivalent to the Department for review annually.

Possess and maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements.

**8.519.27.C Functions of all Transition Coordination Agencies**

In order to be approved as a Transition Coordination Agency, the agency shall perform all of the following functions:

Transition coordination agencies shall be responsible to maintain sufficient documentation of all transition coordination activities performed and to support claims within the Department-designated data system and internal agency records.

Transition coordination agencies may not provide guardianship services for any client for whom they provide transition coordination services.

Transition coordination agencies shall be responsible to maintain, or have access to, information about public and private, state and local services, supports and resources and shall make information available to the client and/or persons inquiring upon their behalf.

Transition coordination agencies shall respond to referrals for transition coordination support within 2 business days and specify whether the referral is accepted or not by completing the Transition Services Referral Form.

Transition coordination agencies shall assign and schedule the first visit with the client within 10 state business days after accepting a referral.

Transition coordination agencies shall assign one (1) primary person who ensures transition coordination is provided on behalf of the client.

Transition coordination agencies shall provide coordination in accordance with state business days as defined in 24-11-101(1) C.R.S.

Transition coordination agencies shall maintain all documents, records, communications, notes, and other materials that relate to any work performed.

Transition coordination agencies shall possess appropriate financial management capacity and systems to document and track services and costs in accordance with state and federal regulation.

In accordance with reporting requirements of the Department's data system, maintain and update records of persons receiving transition coordination.

Transition coordination agencies shall establish and maintain working relationships with community-based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the needs of clients.

Transition coordination agencies shall have a system for recruiting, hiring, evaluating, and terminating employees. Transition coordination agencies' employment policies and practices shall comply with all federal and state laws.

Transition coordination agencies shall ensure staff have access to statutes and regulations relevant to the provision of authorized services and shall ensure that appropriate employees are oriented to the content of statues and regulations.

Transition coordination agencies shall provide transition coordination for clients without discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability.

Transition coordination agencies shall provide information and reports as required by the Department including, but not limited to, data and records necessary for the Department to conduct operations.

Transition coordination agencies shall allow access by authorized personnel of the Department, or its contractors, for the purpose of reviewing services and supports funded by the Department and shall cooperate with the Department in evaluation of such services and supports.

Transition coordination agencies shall establish agency procedures sufficient to execute Transition Coordination according to the provisions of these regulations. Such procedures shall include, but are not limited to:

1. Referral Management.

2. Transition Assessment of community needs.

3. Transition Plan.

4. Risk Mitigation Plan that identifies potential risk factors.

5. Service and support coordination for non-Medicaid transition-related services and supports.

6. Monitoring of the transition and transition plan review.

7. Denial and discontinuation of Transition Coordination.

8. In the case of an interstate transfer to another provider area, transition coordination may be transferred to the provider in the new geographic region with any remaining billable units.

9. Complaint Procedure that includes the requirement to share information, such as points of contact within the agency, to clients, families and referring agencies who may wish to file a complaint.

### 8.519.27.D Qualifications of Transition Coordinators

Transition coordinators must be employed by an approved transition coordination agency.

Transition Coordinator minimum experience:

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

    a. Copy of degree or official transcript must be kept in the transition coordinator's personnel file.

2. If an individual does not meet the minimum requirement, the transition coordination agency shall request a waiver from the Department and demonstrate that the individual meets one of the following:

    a. Experience working with LTSS population, in a private or public agency or lived experience, may substitute for the required education on a year for year basis; or

    b. A combination of LTSS experience and education, demonstrating a strong emphasis in a human behavioral science field.

3. For clients for whom the transition coordinator is providing transition coordination, transition coordinators may not:

    a. Be related by blood or marriage to the client.

    b. Be related by blood or marriage to any paid caregiver of the client.

    c. Be financially responsible for the client.

    d. Be the client's legal guardian, authorized representative, or be empowered to make decisions on the client's behalf through a power of attorney.

### 8.519.27.E Training

Transition coordinators must complete and document the following trainings within 90 days from the date of hire and prior to providing transition coordination services independently:

1. Transition Assessment of community needs and risk factor.

2. Transition Planning.

3. Risk mitigation plan development, monitoring and revision.

4. Referral for non-Medicaid services.

5. Monitoring services.

6. Case documentation.

7. Person-centered approaches to planning and practice.

8. Housing voucher application and housing navigation services.

### 8.519.27.F Functions of transition coordinators

Transition coordinators must also perform all the following activities. These activities are the only activities billable under transition coordination:

1. Coordination of the transition options team (TOT): members of the TOT are convened to work in a cooperative and supportive manner to develop and implement the transition plan, and to serve in an advocacy role to the individual. Responsibilities of team members are to:

    a. Facilitate completion of an assessment which identifies preferences, needs and any risk factors the resident may have in a home or community-based setting within six weeks of accepting a referral.

    b. Participate in the development of a risk mitigation plan to address identified risk factors within six weeks of accepting a referral.

    c. Assist in the identification of supports and services that will be required to address the individual's needs, preferences and risk factors.

    d. Conduct service brokering for non-Medicaid services to determine if the identified necessary supports and services are available at the frequency needed.

    e. Solidify a transition recommendation from the TOT within 10 weeks from the first TOT meeting but not before the first TOT meeting, unless the member chooses to opt out of transition services.

    f. Facilitate completion of a transition plan if the client chooses to proceed with the transition.

2. Pre-transition coordination includes:

    a. Facilitate completion of transition assessment, risk mitigation and transition plans.

    b. Complete, as needed, housing voucher application, including assistance to obtain necessary documents.

    c. Collaborate, as needed, with housing navigation services to obtain a voucher and locate housing.

    d. Assist client to create a transition budget.

    e. Facilitate a community-based living arrangement.

    f. Coordinate any medication, home modification and/or durable medical equipment needs with the nursing facility or HCBS case manager as needed prior to discharge to ensure that all components of transition plan are in place prior to a discharge.

    g. Assist client in preparing for discharge, including being present on day of discharge.

    h. Meet with client at new home on the day of discharge to ensure that services are in place and the household set-up is complete.

3. Post-transition monitoring shall meet the need based on the client's community risk level as documented in the risk mitigation plan. Occur at the frequency and type to meet the client's community risk level documented in the:

    a. The transition coordinator shall ensure that clients receive services in accordance with their transition plan and risk mitigation plan and monitor the quality and adequacy of the services and supports provided to clients.

    b. Monitoring and follow-up activities include making necessary changes to the transition plan and risk mitigation plan.

    c. The level of monitoring shall occur at the frequency and type to meet the client's community risk level.

    d. Monitoring may include as determined by the community risk level:

        i. Face-to-face in the client's residence.

        ii. Face-to face in community.

        iii. By telephone or electronic communication.

4. Post-transition monitoring includes:

    a. Provide support services to aid in sustaining community-based living.

    b. Respond to risk incidents and notify case manager.

    c. Revise risk mitigation plan as needed.

    d. Assess need for independent living skills training.

    e. Problem-solve community integration issues.

    f. Support community integration activities.

    g. Monitor service provision, to include contacting guardians, providers, and case management agencies.

    h. Complete client satisfaction survey prior to discharge and at the end of the transition period to evaluate the client's experience of the following:

        i. Service planning.

        ii. Transition plan implementation.

        iii. Transition coordination process.

        iv. Level and adequacy of services provided.

        v. Overall client satisfaction.

5. Post-transition monitoring may not duplicate services for Life Skills Training (LST), defined in 10 CCR 2505-10, § 8.553.3; Transition Setup defined in 10 CCR 2505-10, § 8.553.4; Home Delivered Meals, defined in 10 CCR 2505-10, § 8.553.5; and Peer Mentorship, defined in 10 CCR 2505-10, § 8.553.6.

**8.519.27.G Conflict of Interest for Transition Coordination Agencies**

If an agency provides both HCBS case management and transition coordination, the same employee must provide both services to a client who is transitioning to an HCBS setting.

If a transition coordination agency also provides services under HCBS waivers, a policy must be in place to avoid conflict of interest and provide a free choice of providers to clients. The HCBS case management agency shall be responsible for all service brokering for Medicaid services.

## 8.520 HOME HEALTH SERVICES

### 8.520.1. Definitions

8.520.1.A. Activities of Daily Living (ADL) means daily tasks that are required to maintain a client's health, and include eating, bathing, dressing, toileting, grooming, transferring, walking, and continence. When a client is unable to perform these activities independently, skilled or unskilled providers may be required for the client's needs.

8.520.1.B. Acute Medical Condition means a medical condition which has a rapid onset and short duration. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

8.520.1.C. Alternative Care Facility means an assisted living residence licensed by the Colorado Department of Public Health and Environment (CDPHE), and certified by the Department of Health Care Policy and Financing (Department) to provide Assisted Living Care Services and protective oversight to clients.

8.520.1.D. Behavioral Intervention means techniques, therapies, and methods used to modify or minimize aggressive (verbal/physical), combative, destructive, disruptive, repetitious, resistive, self-injurious, or other inappropriate behaviors outlined on the CMS-485 Plan of Care (defined below). Behavioral interventions exclude frequent verbal redirection or additional time to transition or complete a task, which are part of the general assessment of the client's needs.

8.520.1.E. Care Coordination means the deliberate organization of client care activities between two or more participants (including the client) for the appropriate delivery of health care and health support services, and organization of personnel and resources needed for required client care activities.

8.520.1.F. Certified Nurse Aide Assignment Form means the form used by the Home Health Agency to list the duties to be performed by the Certified Nurse Aide (CNA) at each visit.

8.520.1.G. Department means the Colorado Department of Health Care Policy and Financing which is designated as the single State Medicaid agency for Colorado, or any divisions or sub-units within that agency.

8.520.1.H. Designee means the entity that has been contracted by the Department to review for the Medical Necessity and appropriateness of the requested services, including Home Health prior authorization requests (PARs). Designees may include case management entities such as Single Entry Points or Community Centered Boards who manage waiver eligibility and review.

8.520.1.I. Home Care Agency means an entity which provides Home Health or Personal Care Services. When referred to in this rule without a 'Class A' or 'Class B' designation, the term encompasses both types of agencies.

8.520.1.J. Home Health Agency means an agency that is licensed as a Class A Home Care Agency in Colorado, and is certified to provide skilled care services to Medicare and Medicaid eligible clients. Agencies shall hold active and current Medicare and Medicaid provider IDs to provide services to Medicaid clients.

8.520.1.K. Home Health Services means those services listed at Section 8.520.5, Service Types.

8.520.1.L. Home Health Telehealth means the remote monitoring of clinical data transmitted through electronic information processing technologies, from the client to the home health provider which meet HIPAA compliance standards.

8.520.1.M. Intermittent means visits that have a distinct start time and stop time, and are task oriented with the goal of meeting a client's specific needs for that visit.

8.520.1.N. Ordering Practitioner means the client's primary care physician, nurse practitioner, clinical nurse specialist, physician assistant, or other physician specialist. For clients in a hospital or nursing facility, the Ordering Practitioner is the appropriate qualified personnel responsible for writing discharge orders until such time as the client is discharged. This definition may include an alternate practitioner authorized by the Ordering Practitioner to care for the client in the Ordering Practitioner's absence.

8.520.1.O. Personal Care Worker means an employee of a licensed Home Care Agency who has completed the required training to provide Personal Care Services, or who has verified experience providing Personal Care Services for clients. A Personal Care Worker shall not perform tasks that are considered skilled CNA services.

8.520.1.P. Place of Residence means where the client lives. Includes temporary accommodations, homeless shelters or other locations for clients who are homeless or have no permanent residence.

8.520.1.Q. Plan of Care means a coordinated plan developed by the Home Health Agency, as ordered by the Ordering Practitioner for provision of services to a client at his or her residence, and periodically reviewed and signed by the practitioner in accordance with Medicare requirements. This shall be written on the CMS-485 ("485") or a document that is identical in content, specific to the discipline completing the plan of care.

8.520.1.R. Pro Re Nata (PRN) means as needed.

8.520.1.S. Protective Oversight means maintaining an awareness of the general whereabouts of a client. Also includes monitoring the client's activity so that a caregiver has the ability to intervene and supervise the safety, nutrition, medication, and other care needs of the client.

**8.520.2. Client Eligibility**

8.520.2.A. Home Health Services are available to all Medicaid clients and to all Old Age Pension Program clients, as defined at Section 8.940, when all program and service requirements in this rule are met.

8.520.2.B. Medicaid clients aged 18 and over shall meet the Level of Care Screening Guidelines for Long-Term Care Services at Section 8.401, to be eligible for Long-Term Home Health Services, as set forth at Section 8.520.4.C.2.

**8.520.3. Provider Eligibility**

8.520.3.A. Services must be provided by a Medicare and Medicaid-certified Home Health Agency.

8.520.3.B. All Home Health Services providers shall comply with the rules and regulations set forth by the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, the Colorado Department of Regulatory Agencies, the Centers for Medicare and Medicaid Services, and the Colorado Department of Labor and Employment.

**8.520.3.C. Provider Agency Requirements**

1. A Home Health Agency must:

   a. Be certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act;

   b. Be a Colorado Medicaid enrolled provider;

   c. Maintain liability insurance for the minimum amount set annually by the Department; and

   d. Be licensed by the State of Colorado as a Class A Home Care Agency in good standing.

2. Home Health Agencies which perform procedures in the client's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 shall possess a certificate of waiver from the Centers for Medicare and Medicaid Services (CMS) or its Designee.

3. Home Health Agencies shall regularly review the Medicaid rules, 10 CCR 2505-10. The Home Health Agency shall make access to these rules available to all staff.

4. A Home Health Agency cannot discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal. The Home Health Agency must provide notice of at least thirty days to the client, or the client’s legal guardian.

5. In the event a Home Health Agency is ceasing operations, or ceasing services to Medicaid clients, the agency will provide notice to the Department’s Home Health Policy Specialist of at least thirty days prior to the end of operations.

**8.520.4. Covered Services**

**8.520.4.A.** Home Health Services are covered under Medicaid only when all of the following are met:

1. Services are Medically Necessary as defined in Section 8.076.1.8;

2. Services are provided under a Plan of Care as defined at Section 8.520.1., Definitions;

3. Services are provided on an Intermittent basis, as defined at Section 8.520.1., Definitions;

4. The client meets one of the following:

   a. The only alternative to Home Health Services is hospitalization or emergency room care; or

   b. Client medical records indicate that medically necessary services should be provided in the client's place of residence, instead of an outpatient setting, according to one or more of the following guidelines:

      i) The client, due to illness, injury or disability, is unable to travel to an outpatient setting for the needed service;

ii) Based on the client's illness, injury, or disability, travel to an outpatient setting for the needed service would create a medical hardship for the client;

iii) Travel to an outpatient setting for the needed service is contraindicated by a documented medical diagnosis;

iv) Travel to an outpatient setting for the needed service would interfere with the effectiveness of the service; or

v) The client's medical diagnosis requires teaching which is most effectively accomplished in the client's place of residence on a short-term basis.

5. The client is unable to perform the health care tasks for him or herself, and no unpaid family/caregiver is able and willing to perform the tasks; and

6. Covered service types are those listed in Service Types, Section 8.520.5.

**8.520.4.B. Place of Service**

1. Services shall be provided in the client's place of residence or one of the following places of service:

a. Assisted Living Facilities (ALFs);

b. Alternative Care Facilities (ACFs);

c. Group Residential Services and Supports (GRSS) including host homes, apartments or homes where three or fewer clients reside. Services shall not duplicate those that are the contracted responsibility of the GRSS;

d. Individual Residential Services and Supports (IRSS) including host homes, apartments or homes where three or fewer clients reside Services shall not duplicate those that are the contracted responsibility of the IRSS; or

e. Hotels, or similar temporary accommodations while traveling, will be considered the temporary place of residence for purposes of this rule.

f. Nothing in this section should be read to prohibit a client from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

g. Telemedicine may be provided in accordance with Section 8.095.

**8.520.4.C. Service Categories**

1. Acute Home Health Services

a. Acute Home Health Services are covered for clients who experience an acute health care need that requires Home Health Services.

b. Acute Home Health Services are provided for 60 or fewer calendar days or until the acute medical condition is resolved, whichever comes first.

c. Acute Home Health Services are provided for the treatment of the following acute medical conditions/episodes:

i) Infectious disease;

ii) Pneumonia;

iii) New diagnosis of a life-altering disease;

iv) Post-heart attack or stroke;

v) Care related to post-surgical recovery;

vi) Post-hospital care provided as follow-up care for medical conditions that required hospitalization, including neonatal disorders;

vii) Post-nursing home care, when the nursing home care was provided primarily for rehabilitation following hospitalization and the medical condition is likely to resolve or stabilize to the point where the client will no longer need Home Health Services within 60 days following initiation of Home Health Services;

viii) Complications of pregnancy or postpartum recovery; or

iv) Individuals who experience an acute incident related to a chronic disease may be treated under the acute home health benefit. Specific information on the acute incident shall be documented in the record.

d. A client may receive additional periods of acute Home Health Services when at least 10 days have elapsed since the client's discharge from an acute home health episode and one of the following circumstances occurs:

i) The client has a change in medical condition that necessitates acute Home Health Services;

ii) New onset of a chronic medical condition; or

iii) Treatment needed for a new acute medical condition or episode.

e. Nursing visits provided solely for the purpose of assessment or teaching are covered only during the acute period under the following guidelines:

i) An initial assessment visit ordered by a physician is covered for determination of whether ongoing nursing or CNA care is needed. Nursing visits for the sole purpose of assessing a client for recertification of Home Health Services shall not be reimbursed if the client receives only CNA services;

ii) The visit instructs the client or client's family member/caregiver in providing safe and effective care that would normally be provided by a skilled home health provider; or

iii) The visit supervises the client or client's family member/caregiver to verify and document that they are competent in providing the needed task.

f. Acute Home Health Services may be provided to clients who receive Health Maintenance tasks through In-Home Supports and Services (IHSS) or Consumer Directed Attendant Supports and Services (CDASS).

g. GRSS group home residents may receive acute Home Health Services.

h. If the acute home health client is hospitalized for planned or unplanned services for 10 or more calendar days, the Home Health Agency may close the client's acute home health episode and start a new acute home health episode when the client is discharged.

i. Acute Care Home Health Limitations:

i) A new period of acute Home Health Services shall not be used for continuation of treatment from a prior Acute Home Health episode. New Acute Episodes must be utilized for a new or worsening condition.

ii) A client who is receiving either Long-Term Home Health Services or HCBS waiver services may receive acute Home Health Services only if the client experiences an event listed in subpart c. as an acute incident, which is separate from the standard needs of the client and makes acute Home Health Services necessary.

iii) If a client's acute medical condition resolves prior to 60 calendar days from onset, the client shall be discharged from acute home health or transitioned to the client's normal Long-Term Home Health services.

2. Long-Term Home Health Services

a. Long-term Home Health Services are covered for clients who have long-term chronic needs requiring ongoing Home Health Services.

b. Long-term Home Health Services may be provided to clients who receive health maintenance tasks through IHSS.

c. Long-term Home Health Services may not be provided to clients who receive health maintenance tasks through CDASS.

d. Long-term Home Health Services are provided:

i) Following the 60th calendar day for acute home health clients who require additional services to meet treatment goals or to be safely discharged from Home Health Services;

ii) On the first day of Home Health Services for clients with well documented chronic needs when the client does not require an acute home health care transition period; or

iii) Continuation of ongoing long-term home health Plan of Care.

e. Long-Term Home Health Limitations:

i) Clients aged 20 and younger may obtain long-term home health physical therapy, occupational therapy, and speech therapy services when Medically Necessary and when:

1) Therapy services will be more effective if provided in the home setting; or

2) Outpatient therapy would create a hardship for the client.

ii) Clients aged 21 and older who continue to require physical therapy, occupational therapy, and speech therapy services after the initial acute home health period may only obtain such long-term services in an outpatient setting.

iii) Clients admitted to long-term Home Health Services through the HCBS waiver program shall meet level of care criteria to qualify for long-term Home Health Services.

iv) Long-term Home Health Services may be provided in GRSS group home settings, when the GRSS provider agency reimburses the Home Health Agency directly for these Home Health Services. Long-term Home Health Service provision in GRSS group homes is not reimbursable through the State Plan.

3. Long-Term with Acute Episode Home Health:

a. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

b. Long-term with acute episode home health is covered if the client is receiving long-term home health services and requires treatment for an acute episode as defined in section 8.520.4.C.1.

**8.520.5. Service Types**

**8.520.5.A. Nursing Services**

1. Standard Nursing Visit

a. Those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards;

b. Those skilled nursing services provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws;

c. Standard Nursing Visits include but are not limited to:

i. 1st medication box fill (medication pre-pouring) of the week;

ii. 1st visit of the day; the remaining visits shall utilize brief nursing units as appropriate;

iii. Insertion or replacement of indwelling urinary catheters;

iv. Colostomy and ileostomy stoma care; excluding care performed by Clients;

v. Treatment of decubitus ulcers (stage 2 or greater);

vi. Treatment of widespread, infected or draining skin disorders;

vii. Wounds that require sterile dressing changes;

viii. Visits for foot care;

ix. Nasopharyngeal, tracheostomy aspiration or suctioning, ventilator care;

x. Bolus or continuous Levin tube and gastrostomy (G-tube) feedings, when formula/feeding needs to be prepared or more than 1 can of prepared formula is needed per bolus feeding per visit, ONLY when there is not an able or willing caregiver; and

xi. Complex Wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

2. Brief Nursing Visits

a. Brief nursing visits for established long-term home health Clients who require multiple visits per day for uncomplicated skilled tasks that can be completed in a shorter or brief visit (excluding the first regular nursing visit of the day)

b. Brief Nursing Visits include, but are not limited to:

i) Consecutive visits for two or more Clients who reside in the same location and are seen by the same Home Health Agency nurse, excluding the first visit of the day;

ii) Intramuscular, intradermal and subcutaneous injections (including insulin) when required multiple times daily, excluding the first visit of the day;

iii) Insulin administration: if the sole reason for a daily visit or multiple visits per day, the first visit of the week is to be treated as a standard nursing visit and all other visits of the week are to be treated as brief nursing visits.

iv) Additional visits beyond the first visit of the day where simple wound care dressings are the sole reason for the visit;

v) Additional visits beyond the first visit of the day where catheter irrigation is the sole reason for the visit;

vi) Additional visits beyond the first visit of the day where external catheterization, or catheter care is the sole purpose for the visit;

vii) Bolus Levin or G-tube feedings of one can of prepared formula excluding the first visit of the day, ONLY when there is no willing or able caregiver and it is the sole purpose of the visit;

viii) Medication box refills or changes following the first medication pre-pouring of the week;

ix) Other non-complex nursing tasks as deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate; or

x) A combination of uncomplicated tasks when deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate.

c. Ongoing assessment shall be billed as brief nursing visits unless the Client experiences a change in status requiring a standard visit. If a standard nursing visit is required for the assessment, the agency shall provide documentation supporting the need on the PAR form and on the Plan of Care for the Department or its Designee.

3. PRN Nursing Visits

a. May be standard nursing visits or brief nursing visits; and

b. Shall include specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

4. Nursing Service Limitations

a. Nursing assessment visits are not covered if provided solely to open or recertify the case for CNA services, physical, occupational, or speech therapy.

b. Nursing visits solely for recertifying a Client are not covered.

c. Nursing visits that are scheduled solely for CNA supervision are not covered.

d. Family member/caregivers, who meet the requirements to provide nursing services and are nurses credentialed by, and in active status with the Department of Regulatory Agencies, may be employed by the Home Health Agency to provide nursing services to a Client, but may only be reimbursed for services that exceed the usual responsibilities of the Family Member/Caregiver.

e. PRN nursing visits may be requested as standard nursing visits or brief nursing visits and shall include a physician’s order with specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

f. Nursing visits are not reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Behavioral Health Organization. Nursing visits for mentally ill Clients are reimbursed under Home Health Services for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

g. Medicaid does not reimburse for two nurses during one visit except when two nurses are required to perform a procedure. For this exception, the provider may bill for two visits, or for all units for both nurses. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

h. Nursing visits provided solely for the purpose of assessing or teaching are reimbursed by the Department only in the following circumstances:

i) Nursing visits solely for the purpose of assessing the Client or teaching the Client or the Client's unpaid family member/caregiver are not reimbursed unless the care is acute home health or long-term home health with acute episode, per Section 8.520.3, or the care is for extreme instability of a chronic medical condition under long-term home health, per Section 8.520.3. Long-term home health nursing visits for the sole purpose of assessing or teaching are not covered.

ii) When an initial assessment visit is ordered by a physician and there is a reasonable expectation that ongoing nursing or CNA care may be needed. Initial nursing assessment visits cannot be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

iii) When a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the Client or the Client's unpaid family member/caregiver how to perform the task, the visit is not considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the Client or unpaid family member/caregiver performing the task to verify that the task is being performed correctly is considered a visit that is solely for the purpose of assessing and teaching and is not covered.

iv) Nursing visits provided solely for the purpose of assessment or teaching cannot exceed the frequency that is justified by the Client's documented medical condition and symptoms. Assessment visits may continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific medical conditions or symptoms which are not stable or not resolved. Teaching visits may be as frequent as necessary, up to the maximum reimbursement limits, to teach the Client or the Client's unpaid family member/caregiver, and may continue only as long as needed to demonstrate understanding or to perform care, or until it is determined that the Client or unpaid family member/caregiver is unable to learn or to perform the skill being taught. The visit in which the nurse determines that there is no longer a need for assessment or teaching shall be reimbursed if it is the last visit provided solely for assessment or teaching.

v) Nursing visits provided solely for the purpose of assessment or teaching are not reimbursed if the Client is capable of self-assessment and of contacting the physician as needed, and if the Client's medical records do not justify a need for Client teaching beyond that already provided by the hospital or attending physician, as determined and documented on the initial Home Health assessment.

vi) Nursing visits provided solely for the purpose of assessment or teaching cannot be reimbursed if there is an available and willing unpaid family member/caregiver who is capable of assessing the Client's medical condition and needs and contacting the physician as needed; and if the Client's medical records do not justify a need for teaching of the Client's unpaid family member/caregiver beyond the teaching already provided by the hospital or attending physician, as determined and documented on the initial Home Health assessment.

i. Nursing visits provided solely for the purpose of providing foot care are reimbursed by Medicaid only if the Client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the Client or unpaid family member/caregiver is not able or willing to provide the foot care.

j. Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit. The clinical record shall indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for foot care to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

i) Absent (not palpable) posterior tibial pulse;

ii) Absent (not palpable) dorsalis pedis pulse;

iii) Three of the advanced trophic changes:

1) Hair growth (decrease or absence),

2) Nail changes (thickening),

3) Pigmentary changes (discoloration),

4) Skin texture (thin, shiny), or

5) Skin color (rubor or redness);

iv) Claudication (limping, lameness);

v) Temperature changes (cold feet);

vi) Edema;

vii) Paresthesia ; or

viii) Burning.

k. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers are reimbursed only if:

i) The Client is not living in a licensed Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at Section 25-1.5-301 C.R.S.;

ii) The Client is not physically or mentally capable of pre-pouring medications or has a medical history of non-compliance with taking medications if they are not pre-poured;

iii) The Client has no unpaid family member/caregiver who is willing or able to pre-pour the medications for the Client; and

iv) There is documentation in the Client's chart that the Client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular Client.

l. The unit of reimbursement for nursing services is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in Client care or treatment.

**8.520.5.B. Certified Nurse Aide Services**

1. CNA services may be provided when a nurse or therapist determines that an eligible client requires the skilled services of a qualified CNA, as such services are defined in this section 8.520.5.B.13

2. CNA tasks shall not duplicate waiver services or the client's residential agreement (such as an ALF, IRSS, GRSS, or other Medicaid reimbursed Residence, or adult day care setting).

3. Skilled care shall only be provided by a CNA when a client is unable to independently complete one or more ADLs. Skilled CNA services shall not be reimbursed for tasks or services that are the contracted responsibilities of an ALF, IRSS, GRSS or other Medicaid reimbursed Residence.

4. Before providing any services, all CNAs shall be trained and certified according to Federal Medicare regulations, and all CNA services shall be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR 484.36. Title 42 of the Code of Federal Regulations, Part 484.36 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

5. If the client receiving CNA services also requires and receives skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist shall make on-site supervisory visits to the client's home no less frequently than every two weeks.

6. If the client receiving CNA services does not require skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse shall make on-site supervisory visits to the client's home no less frequently than every 60 days. Each supervisory visit shall occur while the CNA is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the CNA services, and cannot be billed to Medicaid as nursing visits.

7. Registered nurses and physical, occupational and speech therapists supervising CNAs shall comply with applicable state laws governing their respective professions.

8. CNA services can include personal care and homemaking tasks if such tasks are completed during the skilled care visit and are defined below:

a. Personal care or homemaking services which are directly related to and secondary to skilled care are considered part of the skilled care task, and are not further reimbursed. For clients who are also eligible for HCBS personal care and homemaker services, the units spent on personal care and homemaker services may not be billed as CNA services.

b. Nurse aide tasks performed by a CNA pursuant to the nurse aide scope of practice defined by the State Board of Nursing, but does not include those tasks that are allowed as personal care, at Section 8.535, PEDIATRIC PERSONAL CARE.

c. Personal care means those tasks which are allowed as personal care at Section 8.535, PEDIATRIC PERSONAL CARE, and Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE.

d. Homemaking means those tasks allowed as homemaking tasks at Section 8.490, HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES.

9. CNA services solely for the purpose of behavior management are not a benefit under Medicaid Home Health, because behavior management is outside the nurse aide scope of practice.

10. The usual frequency of all tasks is as ordered by the Ordering Practitioner on the Plan of Care unless otherwise noted.

11. The Home Health Agency shall document the decline in medical condition or the need for all medically necessary skilled tasks.

12. Skilled Certified Nurse Aide Tasks

a. Ambulation

i) Task includes: Walking or moving from place to place with or without assistive device.

ii) Ambulation is a skilled task when:

1) Client is unable to assist or direct care;

2) Hands on assistance is required for safe ambulation and client is unable to maintain balance or to bear weight reliably; or

3) Client has not been deemed independent with assistive devices ordered by a qualified physician.

iii) Special Considerations: Ambulation shall not be a sole reason for a CNA visit.

b. Bathing/Showering

i) Task includes either:

1) Preparation for bath or shower, checking water temperature; assisting client into bath or shower; applying soap and shampoo; rinsing off, towel drying; and all transfers and ambulation related to bathing; all hair care, pericare and skin care provided in conjunction with bathing; or

2) Bed bath or sponge bath.

ii) The usual frequency of this task shall be up to one time daily.

iii) Bathing/Showering is a skilled task when either:

1) Open wound(s), stoma(s), broken skin or active chronic skin disorder(s) are present; or

2) Client is unable to maintain balance or to bear weight due to illness, injury, disability, a history of falls, temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

iv) Special Considerations:

1) Additional baths may be warranted for treatment and shall be documented by physician order and Plan of Care.

2) A second person may be staffed when required to safely bathe the client.

3) Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.

c. Bladder Care

i) Task includes:

1) Assistance with toilet, commode, bedpan, urinal, or diaper;

2) Transfers, skin care, ambulation and positioning related to bladder care; and

3) Emptying and rinsing commode or bedpan after each use.

ii) Bladder Care concludes when the client is returned to a pre-urination state.

iii) Bladder Care is a skilled task when either:

1) Client is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days); or

2) Client requires skilled skin care associated with bladder care or client has been assessed as having a high and ongoing risk for skin breakdown.

d. Bowel Care

i) Task includes:

1) Changing and cleaning incontinent client, or hands on assistance with toileting; and

2) Returning client to pre-bowel movement status, which includes transfers, skin care, ambulation and positioning related to bowel care.

ii) Bowel care is a skilled task when either:

1) Client is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days) is present; or

2) Client requires skilled skin care associated with bowel care or client has been assessed as having a high and ongoing risk for skin breakdown.

e. Bowel Program

i) Skilled Task includes:

1) Administering bowel program as ordered by the client's qualified physician, including digital stimulation, administering enemas, suppositories, and returning client to pre-bowel program status; or

2) Care of a colostomy or ileostomy, which includes emptying the ostomy bag, changing the ostomy bag and skin care at the site of the ostomy and returning the client to pre-procedure status.

ii) Special Considerations

1) To perform the task, the client must have a relatively stable or predictable bowel program/condition and a qualified physician deems that the CNA is competent to provide the client-specific program.

2) Use of digital stimulation and over-the-counter suppositories or over-the-counter enema (not to exceed 120ml) only when the CNA demonstrates competence in the Home Health Agency's Policies & Procedures for the task. (Agencies may choose to delegate this task to the CNA.)

f. Catheter Care

i) Task includes:

1) Care of external, Foley and Suprapubic catheters;

2) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care;

3) Emptying catheter bags; and

4) Transfers, skin care, ambulation and positioning related to the catheter care.

ii) The usual frequency of this task shall not exceed two times daily.

iii) Catheter care is a skilled task when either:

1) Emptying catheter collection bags (indwelling or external) includes a need to record and report the client's urinary output to the client's nurse; or

2) The indwelling catheter tubing needs to be opened for any reason and the client is unable to do so independently.

iv) Special Considerations: Catheter care shall not be the sole purpose of the CNA visit.

g. Dressing

i) Task includes:

1) Dressing and undressing with ordinary clothing, including pantyhose or socks and shoes;

2) Placement and removal of braces and splints; and

3) All transfers and positioning related to dressing and undressing.

ii) The usual frequency of this task shall not exceed twice daily.

iii) Dressing is a skilled task when:

1) Client requires assistance with the application of anti-embolic or pressure stockings and placement of braces or splints that can be obtained only with a prescription from a qualified physician; or

2) Client is unable to assist or direct care; or

3) Client experiences a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

iv) Special Considerations: Hand-over-hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.

h. Exercise/Range of Motion (ROM)

i) Task includes: ROM and other exercise programs prescribed by a therapist or qualified physician, and only when the client is not receiving exercise/ROM from a therapist or a doctor on the same day.

ii) Exercise/Range of Motion (ROM) is a skilled task when: The exercise/ROM, including passive ROM, is prescribed by a qualified physician and the CNA has demonstrated competency.

iii) Special Considerations: The Home Health Agency shall ensure the CNA is trained in the exercise program. The Home Health Agency shall maintain the exercise program documentation in the client record and it shall be evaluated/renewed by the qualified physician or therapist with each Plan of Care.

i. Feeding

i) Task includes:

1) Ensuring food is the proper temperature, cutting food into bite-size pieces, and ensuring the food is proper consistency;

2) Placing food in client's mouth; and

3) Gastric tube (g-tube) formula preparation, verifying placement and patency of tube, administering tube feeding and flushing tube following feeding if the Home Health Agency and supervising nurse deem the CNA competent.

ii) The usual frequency of this task shall not exceed three times daily.

iii) Feeding is a skilled task when:

1) Client is unable to communicate verbally, non-verbally or through other means;

2) Client is unable to be positioned upright;

3) Client is on a modified texture diet;

4) Client has a physiological or neurogenic chewing or swallowing problem;

5) Client is on mechanical ventilation;

6) Client requires oral suctioning;

7) A structural issue (such as cleft palate) or other documented swallowing issues are present; or

8) Client has a history of aspirating food.

iv) Special Considerations:

1) There shall be a documented decline in medical condition or an ongoing need documented in the client’s record.

2) A Home Health Agency may allow a CNA to perform a syringe feeding and tube feeding if the CNA is deemed competent.

j. Hygiene – Hair Care/Grooming

i) Task includes: Shampooing, conditioning, drying, and combing.

ii) Task does not include perming, hair coloring, or other extensive styling including, but not limited to, updos, placement of box braids or other elaborate braiding or placing hair extensions.

iii) Task may be completed during skilled bath/shower.

iv) The usual frequency of this task shall not exceed twice daily.

v) Hygiene – Hair Care/Grooming is a skilled task when:

1) Client is unable to complete task independently;

2) Client requires shampoo/conditioner that is prescribed by a qualified physician and dispensed by a pharmacy; or

3) Client has open wound(s) or stoma(s) on the head.

vi) Special Considerations:

1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.

2) Styling of hair is never considered a skilled task.

k. Hygiene – Mouth Care

i) Task includes:

1) Brushing teeth;

2) Flossing;

3) Use of mouthwash;

4) Denture care;

5) Swabbing (toothette); or

6) Oral suctioning.

ii) The usual frequency of this task is up to three times daily.

iii) Hygiene – Mouth Care is a skilled task when:

1) Client is unconscious;

2) Client has difficulty swallowing;

3) Client is at risk for choking and aspiration;

4) Client requires oral suctioning;

5) Client has decreased oral sensitivity or hypersensitivity; or

6) Client is on medications that increase the risk of bleeding of the mouth.

iv) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.

l. Hygiene – Nail Care

i) Task includes: Soaking, filing, and nail trimming.

ii) The usual frequency of this task shall not exceed one time weekly.

iii) Hygiene – Nail Care is a skilled task when:

1) The client has a medical condition that involves peripheral circulatory problems or loss of sensation;

2) The client is at risk for bleeding; or

3) The client is at high risk for injury secondary to the nail care.

iv) Nail Care shall only be completed by a CNA who has been deemed competent in nail care by the Home Health Agency for this population.

v) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.

m. Hygiene – Shaving

i) Task includes: shaving of face, legs and underarms with manual or electric razor.

ii) The usual frequency of this task shall not exceed once daily; task may be completed with bathing/showering.

iii) Hygiene – Shaving is a skilled task when:

1) The client has a medical condition involving peripheral circulatory problems;

2) The client has a medical condition involving loss of sensation;

3) The client has an illness or takes medications that are associated with a high risk for bleeding; or

4) The client has broken skin at/near shaving site or a chronic active skin condition.

iv) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.

n. Meal Preparation

i) Task includes:

1) Preparation of food, ensuring food is proper consistency based on the client's ability to swallow food safely; or

2) Formula preparation.

ii) The usual frequency of this task shall not exceed three times daily.

iii) Meal Preparation is a skilled task when: Client's diet requires either nurse oversight to administer correctly, or meals requiring a modified consistency.

o. Medication Reminders

i) Task includes:

1) Providing client reminders that it is time to take medications;

2) Handing of pre-filled medication box to client;

3) Handing of labeled medication bottle to client; or

4) Opening of prefilled box or labeled medication bottle for client.

ii) This task may be completed by a CNA during the course of a visit, but cannot be the sole purpose of the visit.

iii) A CNA may not perform this task, unless the CNA meets the DORA-approved CNA-MED certification, at 3 C.C.R. § 716-1 Chapter 19 Section 6. If the CNA does not meet the DORA certifications, the CNA may still ask if the client has taken medications and may replace oxygen tubing and may set oxygen to ordered flow rate.

iv) Special Considerations: CNAs shall not administer medications without obtaining the CNA-MED certification from the DORA approved course. 3 C.C.R. 716-1 Chapter 19 Section 6. If the CNA has obtained this certification, the CNA may perform pre-pouring and medication administration within the scope of CNA-MED certification at 3 C.C.R. 716-1 Chapter 19 Section 3.

p. Positioning

i) Task includes:

1) Moving the client from the starting position to a new position while maintaining proper body alignment and support to a client's extremities, and avoiding skin breakdown; and

2) Placing any padding required to maintain proper alignment.

3) Positioning as a stand-alone task excludes positioning that is completed in conjunction with other Activities of Daily Living.

ii) Positioning is a skilled task when:

1) Client is unable to communicate verbally, non-verbally or through other means;

2) Client is not able to perform this task independently due to illness, injury or disability; or

3) Client has temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

4) Positioning the client requires adjusting the client's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a qualified physician.

iii) Special Considerations:

1) The Home Health Agency shall coordinate visits to ensure that effective scheduling is utilized for skilled Intermittent visits.

2) Positioning cannot be the sole reason for a visit.

q. Skin Care

i) Task includes:

1) Applying lotion or other skin care product, when it is not performed in conjunction with bathing or toileting tasks.

ii) Skin care is a skilled task when:

1) Client requires additional skin care that is prescribed by a qualified physician or dispensed by a pharmacy;

2) Client has broken skin; or

3) Client has a wound(s) or active skin disorder and is unable to apply product independently due to illness, injury or disability.

iii) Special Considerations:

1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.

2) This task may be included with positioning.

r. Transfers

i) Task includes:

1) Moving the client from one location to another in a safe manner.

ii) It is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care or other CNA task.

iii) Transfers is a skilled task when:

1) Client is unable to communicate verbally, non-verbally or through other means;

2) Client is not able to perform this task independently due to fragility of illness, injury or disability;

3) Client has a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability;

4) Client lacks the strength and stability to stand or bear weight reliably;

5) Client is not deemed independent in the use of assistive devices or Durable Medical Equipment that has been ordered by a qualified physician; or

6) Client requires a mechanical lift for safe transfers. In order to transfer clients via a mechanical lift, the CNA shall be deemed competent in the particular mechanical lift used by the client.

iv) Special Considerations:

1) A second person may be used when required to safely transfer the client.

2) Transfers may be completed with or without mechanical assistance.

3) Any unskilled task which requires a skilled transfer shall be considered a skilled task.

s. Vital Signs Monitoring

i) Task includes:

1) Taking and reporting the temperature, pulse, blood pressure and respiratory rate of the client.

2) Blood glucose testing and pulse oximetry readings only when the CNA has been deemed competent in these measures.

ii) Vital sign monitoring is always a skilled task.

iii) Special Considerations:

1) Shall only be performed when delegated by the client's nurse. Vital signs monitoring cannot be the sole purpose of the CNA visit.

2) Vital signs shall be taken only as ordered by the client's nurse or the Plan of Care and shall be reported to the nurse in a timely manner.

3) The CNA shall not provide any intervention without the nurse's direction, and may only perform interventions that are within the CNA practice act and for which the CNA has demonstrated competency.

13. Certified Nurse Aide Limitations

a. In accordance with the Colorado Nurse Aide Practice Act, a CNA shall only provide services that have been ordered on the Home Health Plan of Care as written by the Ordering Practitioner.

b. CNAs assist with Activities of Daily Living and cannot perform a visit for the purpose of behavior modification. When a client's disabilities involve behavioral manifestations, the CNA shall follow all applicable behavioral plans and refrain from actions that will escalate or upset the client. In such cases the guardian, case manager, behavioral professional or mental health professional shall provide clear direction to the agency for the provision of care. The CNA shall not perform Behavioral Interventions, beyond those listed in c. of this section.

c. If the client has a behavior plan created by a behavior or mental health professional, the CNA shall follow this plan within their scope and training to the same extent that a family client or paraprofessional in a school would be expected to follow the plan.

d. When an agency allows a CNA to perform skilled tasks that require competency or delegation, the agency shall have policies and procedures regarding its process for determining the competency of the CNA. All competency testing and documentation related to the CNA shall be retained in the CNA's personnel file.

e. CNA services can only be ordered when the task is outside of the usual responsibilities of the client's family member/caregiver.

f. Cuing or hand over hand assistance to complete Activities of Daily Living is not considered a skilled task, however, the agency may provide up to 90 days of care to teach a client Activities of Daily Living when the client is able to learn to perform the tasks independently. Cuing or hand over hand care that exceeds 90 days, or is provided when the client has not had a change in ability to complete self-care techniques, is not covered. If continued cuing or hand over hand assistance is required after 90 days, this task shall be transferred to a Personal Care Worker or other competent individual who can continue the task.

g. Personal care needs or skilled CNA services that are the contracted responsibility of an ALF, GRSS or IRSS are not reimbursable as a separate Medicaid Home Health Service.

h. Family members/caregivers who meet all relevant requirements may be employed as a client's CNA, but may only provide services that are identified in this benefit coverage standard as skilled CNA services and that exceed the usual responsibilities of the family member/caregiver. Family member/caregiver CNAs must meet all CNA requirements.

i. All CNAs who provide Home Health Services shall be subject to all requirements set forth by the policies of the Home Health Agency, and all applicable State and Federal laws.

j. When a CNA holds other licensure(s) or certification(s), but is employed as or functions as a CNA, the services are reimbursed at the CNA rate for services.

k. CNA visits cannot be approved for, nor can extended units be billed for the sole purpose of completing personal care, homemaking tasks or instrumental Activities of Daily Living.

l. Personal care needs for clients ages twenty years and under, not directly related to a skilled care task, shall be addressed through Section 8.535, PEDIATRIC PERSONAL CARE.

m. Homemaker Services provided as directly related tasks secondary to skilled care during a skilled CNA visit shall be limited to the permanent living space of the client. Such services are limited to tasks that benefit the client and are not for the primary benefit of other persons living in the home.

n. Nursing or CNA visits, or requests for extended visits, for the sole purpose of Protective Oversight are not reimbursable by Medicaid.

o. CNA services for the sole purpose of providing personal care or homemaking services are not covered.

p. The Department does not reimburse for services provided by two CNAs to the same client at the same time, except when two CNAs are required for transfers, there are no other persons available to assist, and the reason why adaptive equipment cannot be used instead is documented in the Plan of Care. For this exception, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

q. The basic unit of reimbursement for CNA services is up to one hour. A unit of time that is less than fifteen minutes cannot be reimbursed as a basic unit.

r. For CNA visits that last longer than one hour, extended units may be billed in addition to the basic unit. Extended units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes cannot be reimbursed as an extended unit.

14. Certified Nurse Aide (CNA) Supervision

a. CNA services shall be supervised by a registered nurse, by the physical therapist, or when appropriate, the speech therapist or occupational therapist depending on the specific Home Health Services the client is receiving.

b. If the client receiving CNA services is also receiving skilled nursing care or physical therapy or occupational therapy, the supervising registered nurse or therapist shall make supervisory visits to the client's home no less frequently than every 14 days. The CNA does not have to be present for every supervisory visit. However, the registered nurse, or the therapist shall make on-site supervisory visits to observe the CNA in the client's home at least every 60 days.

c. If the client is only receiving CNA services, the supervising registered nurse or the physical therapist shall make on-site supervisory visits to observe the CNA in the client's home at least every 60 days.

d. The Department does not reimburse for any visit made solely for the purpose of supervising the CNA.

e. For all clients expected to require CNA services for at least a year, during supervisory visits the supervising nurse shall:

i) Obtain input from the client, or the client's designated representative into the Certified Nurse Aide Assignment Form, including all CNA tasks to be performed during each scheduled time period.

ii) Document details, duties, and obligations on the Certified Nurse Aide Assignment Form.

iii) Assure the Certified Nurse Aide Assignment Form contains information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information pertinent to the care to be provided by the CNA.

iv) Obtain the client's, or the client's authorized representative's, per section 8.520.7.E.1, signature on the form, and provide a copy to the client at the beginning of services, and at least once per year thereafter. A new copy of the Written Notice of Home Care Consumer Rights form, per section 8.520.7.E.1, shall also be provided at these times.

v) Explain the rights listed in the patient's rights form whenever the Certified Nurse Aide Assignment Form is renegotiated and rewritten.

vi) For purposes of complying with this requirement, once per year means a date within one year of the prior certification.

15. If a client does not meet the factors that make a task skilled, as outlined in Section 8.520.5., the client may be eligible to receive those services as unskilled personal care through Section 8.535, PEDIATRIC PERSONAL CARE, or Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE.

**8.520.5.C. Therapy Services**

1. Therapies are only covered:

a. In acute home health care; or

b. Clients 20 years of age or younger may receive long-term home health therapy when services are medically necessary.

c. When the client's Ordering Practitioner prescribes therapy services, and the therapist is responsible for evaluating the client and creating a treatment plan with exercises in accordance with practice guidelines.

2. The therapist shall teach the client, the client's family member/caregiver and other clients of the Home Health care team to perform the exercises as necessary for an optimal outcome.

3. When the therapy Plan of Care includes devices and equipment, the therapist shall assist the client in initiating or writing the request for equipment and train the client on the use of the equipment.

4. Home Health Agencies shall only provide physical, occupational, or speech therapy services when:

   a. Improvement of functioning is expected or continuing;

   b. The therapy assists in overcoming developmental problems;

   c. Therapy visits are necessary to prevent deterioration;

   d. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration, and to teach CNAs or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; or

   e. Therapy visits are indicated to assess the safety or optimal functioning of the client in the home, or to train in the use of equipment used in implementation of the therapy Plan of Care.

5. Physical Therapy

   a. Physical therapy includes any evaluations and treatments allowed under state law at C.R.S. 12- 41-101 through 130, which are applicable to the home setting.

   b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.

   c. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation in Medicare, at 42 CFR 484.4; and who meets all requirements under state law. Title 42 of the Code of Federal Regulations, Part 484.4 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

i) Physical therapy assistants (PTA) can render Home Health therapy but shall practice under the supervision of a registered physical therapist.

d. For clients who do not require skilled nursing care, the physical therapist may open the case and establish the Plan of Care.

e. Physical therapists are responsible for completing client assessments related to various physical skills and functional abilities.

f. Physical therapy includes evaluations and treatments allowed under state law and is available to all acute home health clients and pediatric long-term Home Health clients. Therapy plans and assessments shall contain the therapy services requested; the specific procedures and modalities to be used, including amount, duration, and frequency; and specific goals of therapy service provision.

g. Limitations

i) Physical therapy for clients age 21 or older is not covered for acute care needs when treatment becomes focused on maintenance, and no further functional progress is apparent or expected to occur.

ii) Physical therapy is not a benefit for adult long-term home health clients. Clients 20 years of age or younger may receive Long-Term Home Health therapy services when services are medically necessary.

iii) Clients ages 21 and older who continue to require therapy after the acute home health period may obtain long-term therapy services in an outpatient setting. Clients shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

iv) Clients 20 years of age or younger may obtain therapy services for maintenance care through acute home health and through long-term home health.

v) Physical therapy visits for the sole purpose of providing massage or ultrasound are not covered.

vi) Medicaid does not reimburse for two physical therapists during one visit.

vii) The unit of reimbursement for physical therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

6. Occupational Therapy

a. Occupational therapy includes evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.

b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request and shall assist in training the client on the use of the equipment.

c. Treatment shall be provided by or under the supervision of a registered occupational therapist who meets the qualifications prescribed by federal regulations for participation under applicable federal and state laws, including Medicare requirements at 42 CFR 484.4.

i) Occupational therapy assistants (OTA) can render Home Health therapy but shall practice under the supervision of a registered occupational therapist.

d. For clients who do not require skilled nursing care, the occupational therapist may open the case and establish the Plan of Care.

e. Occupational therapy includes only evaluations and treatments that are allowed under state law for occupational therapists.

f. Occupational therapists shall create a plan and perform assessments which state the specific therapy services requested, the specific procedures and modalities to be used, the amount, duration, frequency, and the goals of the therapy service provision.

g. Limitations

i) Occupational therapy for clients age 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance and no further functional progress is apparent or expected to occur.

ii) Occupational therapy is not a benefit for adult long-term home health clients.

iii) Clients ages 21 and older who continue to require therapy after the acute home health period may only obtain long-term therapy services in an outpatient setting.

iv) Clients shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

v) Clients 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.

vi) Medicaid does not reimburse for two occupational therapists during one visit.

vii) The unit of reimbursement for occupational therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

7. Speech Therapy

a. Speech therapy services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.

b. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.

c. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4.

d. For clients who do not require skilled nursing care, the speech therapist may open the case and establish the Medicaid plan of care.

e. The speech/language pathologist shall state the specific therapy services requested, the specific procedures and modalities to be used, as well as the amount, duration, frequency and specific goals of therapy services on the Plan of Care.

f. Limitations

i) Speech therapy for clients age 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance and no further functional progress is apparent or expected to occur.

ii) Clients cannot be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

iii) Speech therapy is not a benefit for adult long-term home health clients.

iv) Treatment of speech and language delays is only covered when associated with a chronic medical condition, neurological disorder, acute illness, injury, or congenital issue.

v) Clients 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.

vi) Medicaid does not reimburse for two speech therapists during one visit.

vii) The unit of reimbursement for speech therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

**8.520.5.D. Home Health Telehealth Services**

1. The Home Health Agency shall create policies and procedures for the use and maintenance of the monitoring equipment and the process of telehealth monitoring. This service shall be used to monitor the client and manage the client's care, and shall include all of the following elements:

a. The client's designated registered nurse or licensed practical nurse, consistent with state law, shall review all data collected within 24 hours of receipt of the ordered transmission, or in cases where the data is received after business hours, on the first business day following receipt of the data;

b. The client's designated nurse shall oversee all planned interventions;

c. Client-specific parameters and protocols defined by the agency staff and the client's authorizing physician or podiatrist; and

d. Documentation of the clinical data in the client's chart and a summary of response activities, if needed.

i) The nurse assessing the clinical data shall sign and date all documentation; and

ii) Documentation shall include the health care data that was transmitted and the services or activities that are recommended based on the data.

2. The Home Health Agency shall provide monitoring equipment that possesses the capability to measure any changes in the monitored diagnoses, and meets all of the following requirements:

a. FDA certified or UL listed, and used according to the manufacturer's instructions;

b. Maintained in good repair and free from safety hazards; and

c. Sanitized before installation in a client's home.

3. Home Health Telehealth services are covered for clients receiving Home Health Services, when all of the following requirements are met:

a. Client receives services from a home health provider for at least one of the following diagnoses:

i) Congestive Heart Failure;

ii) Chronic Obstructive Pulmonary Disease;

iii) Asthma;

iv) Diabetes;

v) Pneumonia; or

vi) Other diagnosis or medical condition deemed eligible by the Department or its Designee.

b. Client requires ongoing and frequent monitoring, minimum of five times weekly, to manage their qualifying diagnosis as defined and ordered by a physician or podiatrist;

c. Client has demonstrated a need for ongoing monitoring as evidenced by:

i) Having been hospitalized or admitted to an emergency room two or more times in the last twelve months for medical conditions related to the qualifying diagnosis;

ii) If the client has received Home Health Services for less than six months, the client was hospitalized at least once in the last three months;

iii) An acute exacerbation of a qualifying diagnosis that requires telehealth monitoring; or

iv) New onset of a qualifying disease that requires ongoing monitoring to manage the client in their residence.

d. Client or caregiver misses no more than five transmissions of the provider and agency prescribed monitoring events in a thirty-day period; and

e. Client's home environment has the necessary connections to transmit the telehealth data to the agency and has space to set up and use the equipment as prescribed.

4. The Home Health Agency shall make at least one home health nursing visit every 14 days to a client using Home Health Telehealth services.

5. The Home Health Agency shall develop agency-specific criteria for assessment of the need for Home Health Telehealth services, to include patient selection criteria, home environment compatibility, and patient competency. The agency shall complete these assessment forms prior to the submission of the enrollment application and they shall be kept on file at the agency.

6. The client and/or caregiver shall comply with the telehealth monitoring as ordered by the qualifying physician.

7. Limitations:

a. Clients who are unable to comply with the ordered telehealth monitoring shall be disenrolled from the services.

b. Services billed prior to obtaining approval to enroll a client into Home Health Telehealth services by the Department or its Designee are not a covered benefit.

c. The unit of reimbursement for Home Health Telehealth is one calendar day.

i) The Home Health Agency may bill one initial installation unit per client lifetime when the monitoring equipment is installed in the home.

ii) The Home Health Agency may bill the daily rate for each day the telehealth monitoring equipment is used to monitor and manage the client's care.

d. Once per lifetime per client, a Home Health Agency may bill for the installation of the Home Health Telehealth equipment.

**8.520.6 Supplies**

8.520.6.A. Reimbursement for routine supplies is included in the reimbursement for nursing, CNA, physical therapy, occupational therapy, and speech therapy services. Routine supplies are supplies that are customarily used during the course of home care visits. These are standard supplies utilized by the Home Health Agency staff, and not designated for a specific client.

8.520.6.B. Non-routine supplies may be a covered benefit when approved by the Department or its Designee.

8.520.6.C. Limitations

1. A Home Health Agency cannot require a client to purchase or provide supplies that are necessary to carry out the client's Plan of Care.

2. A client may opt to provide his or her own supplies.

**8.520.7. Documentation**

8.520.7.A. Home Health Agencies shall have written policies regarding nurse delegation.

8.520.7.B. Home Health Agencies shall have written policies regarding maintenance of clients' durable medical equipment, and make full disclosure of these policies to all clients with durable medical equipment in the home. The Home Health Agency shall provide such disclosure to the client at the time of intake.

8.520.7.C. Home Health Agencies shall have written policies regarding procedures for communicating with case managers of clients who are also enrolled in HCBS programs. Such policies shall include, at a minimum:

1. How agencies will inform case managers that services are being provided or are being changed; and

2. Procedures for sending copies of Plans of Care if requested by case managers. These policies shall be developed with input from case managers.

**8.520.7.D. Plan of Care Requirements**

1. The client's Ordering Practitioner shall order Home Health Services in writing, as part of a written Plan of Care. The written Plan of Care shall be updated every 60 calendar days but need not be provided to the Department or its Designee unless the client's status has changed significantly, a new PAR is needed, or if requested by the Department or its Designee.

2. The initial assessment or continuation of care assessments shall be completed by a registered nurse, or by a physical therapist, occupational therapist or speech therapist when no skilled nursing needs are required. The assessment shall be utilized to develop the Plan of Care with provider input and oversight. The written Plan of Care and associated documentation shall be used to complete the CMS-485 (or a document that is identical in content) and shall include:

   a. Identification of the Ordering Practitioner;

   b. Ordering Practitioner orders;

   c. Identification of the specific diagnoses, including the primary diagnosis, for which Medicaid Home Health Services are requested.

   d. The specific circumstances, client medical condition(s) or situation(s) that require services to be provided in the client's residence rather than in a Ordering Practitioner's office, clinic or other outpatient setting including the availability of natural supports and the client's living situation;

e. A complete list of supplements, and medications, both prescription and over the counter, along with the dose, the frequency, and the means by which the medication is taken;

f. A complete list of the client's allergies;

g. A list of all non-routine durable medical equipment used by the client;

h. A list of precautions or safety measures in place for the client, as well as functional limitations or activities permitted by the client's qualified physician;

i. A behavioral plan when applicable. Physical Behavioral Interventions, such as restraints, shall not be included in the home health Plan of Care;

j. A notation regarding the client's Ordering Practitioner-ordered dietary (nutritional) requirements and restrictions, any special considerations, other restrictions or nutritional supplements;

k. The Home Health Agency shall indicate a comprehensive list of the amount, frequency, and expected duration of provider visits for each discipline ordered by the client's Ordering Practitioner, including:

i) The specific duties, treatments and tasks to be performed during each visit;

ii) All services and treatments to be provided on the Plan of Care;

1) Treatment plans for physical therapy, occupational therapy and speech therapy may be completed on a form designed specifically for therapy Plans of Care; and

iii) Specific situations and circumstances that require a PRN visit, if applicable.

l. Current clinical summary of the client's health status, including mental status, and a brief statement regarding homebound status of the client;

m. The client's prognosis, goals, rehabilitation potential and where applicable, the client's specific discharge plan;

i) If the client's illness, injury or disability is not expected to improve, or discharge is not anticipated, the agency is not required to document a discharge plan;

ii) The client's medical record shall include the reason that no discharge plan is present;

n. The Ordering Practitioner shall approve the Plan of Care with a dated signature. If an electronic signature is used, the agency shall document that an electronic signature was used and shall keep a copy of the Ordering Practitioner's physical signature on file;

o. Brief statement regarding the client's support network including the availability of the client's family member/caregiver and if applicable, information on why the

client's family member/caregiver is unable or unwilling to provide the care the client requires; and

p. Other relevant information related to the client's need for Home Health care.

3. A new Plan of Care shall be completed every 60 calendar days while the client is receiving Home Health Services. The Plan of Care shall include a statement of review by the Ordering Practitioner every 60 days.

4. Home Health Agencies shall send new Plans of Care and other documentation as requested by the Department or its Designee.

**8.520.7.E. Additional Required Client Chart Documentation**

1. A signed copy of the Written Notice of Home Care Consumer Rights as required by the Department and at 42 CFR 484.10. Title 42 of the Code of Federal Regulations, Part 484.10 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;

2. Evidence of a face-to-face visit with the client's referring provider, or other appropriate provider, as required at 42 CFR 440.70. Title 42 of the Code of Federal Regulations, Part 440.70 (2016) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;

3. A signed and dated copy of the Agency Disclosure Form as required by the Department, with requirements at 42 CFR 484.12. Title 42 of the Code of Federal Regulations, Part 484.12 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;

4. Dates of the most recent hospitalization or nursing facility stay. If the most recent stay was within the last 90 days, reason for the stay (diagnoses), length of stay, summary of treatment, date and place discharged to shall be included in the clinical summary or update;

5. The expected health outcomes, which may include functional outcomes;

6. An emergency plan including the safety measures that will be implemented to protect against injury;

7. A specific order from the client's qualified physician for all PRN visits utilized;

8. Clear documentation of skilled and non-skilled services to be provided to the client with documentation that the client or client's family member/caregiver agrees with the Plan of Care;

9. Accurate and clear clinical notes or visit summaries from each discipline for each visit that include the client's response to treatments and services completed during the visit. Summaries shall be signed and dated by the person who provided the service. If an electronic signature is used, the agency shall document that an electronic signature was used and keep a copy of the physical signature on file;

10. Documented evidence of Care Coordination with the client's other providers;

11. When the client is receiving additional services (skilled or unskilled) evidence of Care Coordination between the other services shall be documented and include an explanation of how the requested Home Health Services do not overlap with these additional services;

12. A plan for how the agency will cover client services (via family member/caregiver or other agency staff) if inclement weather or other unforeseen incident prevents agency staff from delivering the Home Health care ordered by the qualified physician; and

13. If foot or wound care is ordered for the client, the Home Health Agency shall ensure the signs and symptoms of the disease process/medical condition that requires foot or wound care by a nurse are clearly and specifically documented in the clinical record. The Home Health Agency shall ensure the clinical record includes an assessment of the foot or feet, or wound, and physical and clinical findings consistent with the diagnosis, and the need for foot or wound care to be provided by a nurse.

**8.520.8 Prior Authorization**

**8.520.8.A. General Requirements**

1. Approval of the PAR does not guarantee payment by Medicaid.

2. The client and the HHA shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations.

3. Medicaid is always the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to only bill for Medicaid approved services to Medicare or other third party insurance prior to billing Medicaid.

    a. Exceptions to this include Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP) and the following services that are not a skilled Medicare benefit (CNA services only, OT services only, Med-box pre-pouring and routine lab draws).

**8.520.8.B. Acute Home Health**

1. Acute Home Health Services do not require prior authorization. This includes episodes of acute home health for long-term home health clients.

2. If a client receiving long-term Home Health Services experiences an acute care event that necessitates moving the client to an acute home health episode, the agency shall notify the Department or its Designee that the client is moving from long-term home health to acute Home Health Services.

3. If the client's acute home health needs resolve prior to 60 calendar days, the Home Health Agency shall discharge the client, or submit a PAR for long-term Home Health Services if the client is eligible.

    a. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 9 calendar days or less, the Home Health Agency shall resume the client's care under the current acute home health Plan of Care.

    b. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 10 calendar days or more, the Home Health Agency may start a new Acute Home Health episode when the client returns to the Home Health Agency.

    c. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within 10 working days of the beginning and within 10 working days of the end of the acute care episode.

**8.520.8.C. Long-Term Home Health**

1. Long-term Home Health Services do not require prior authorization under Section 8.017.E.

2. When an agency accepts an HCBS waiver client to long-term Home Health Services, the Home Health Agency shall contact the client's case management agency to inform the case manager of the client's need for Home Health Services.

2. When an agency accepts an HCBS waiver client to long-term Home Health Services, the Home Health Agency shall contact the client's case management agency to inform the case manager of the client's need for Home Health Services.

3. The complete formal written PAR shall include:

    a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;

b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services;

c. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance;

d. Any other medical information which will document the medical necessity for the Home Health Services;

e If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;

f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the client's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and

g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.

h. Long Term Home Health Services for clients 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.

4. Authorization time frames:

a. PARs shall be submitted for, and may be approved for up to a one year period.

b The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.

c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the CMS-485.

5. The PAR shall not be backdated to a date prior to the 'from' date of the CMS-485.

6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding clients:

a. PAR Approval: If services requested are in compliance with Medicaid rules are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (e.g, the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician

ii) When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client, through August 31, 2022. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

c. Interim Services: Services provided during the period between the provider's submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.

**8.520.8.D. EPSDT Services**

1. Home Health Services beyond those allowed in Section 8.520.5, for clients ages 0 through 20, shall be reviewed for medical necessity under the EPSDT requirement, as defined at Section 8.280.1.

2. Home Health Services beyond those in Section 8.520.5, which are provided under the Home Health benefit due to medical necessity, cannot include services that are available under other Colorado Medicaid benefits for which the client is eligible, including, but not limited to, Private Duty Nursing, Section 8.540; HCBS Personal Care, Section 8.489; Pediatric Personal Care, Section 8.535; School Health and Related Services, Section 8.290, or Outpatient Therapies, Section 8.200.3.A.6, Section 8.200.5 and Section 8.200.3.D Exceptions may be made if EPSDT Home Health Services will be more cost-effective, provided that client safety is assured. Such exceptions shall, in no way, be construed as mandating the delegation of nursing tasks.

3. PARs for EPSDT home health shall be submitted and reviewed as outlined in Section 8.520.8, including all documentation outlined in Section 8.520.8, and any other medical information which will document the medical necessity for the EPSDT Home Health Services. The Plan of Care shall include the place of service for each home health visit.

**8.520.8.E. Home Health Telehealth Services**

1. Home Health Telehealth services require prior authorization.

2. The Home Health Telehealth PAR shall include all of the following:

   a. A completed enrollment form;

   b. An order for telehealth monitoring signed and dated by the Ordering Practitioner or podiatrist;

   c. A Plan of Care, which includes nursing and therapy assessments for clients. Telehealth monitoring shall be included on the CMS-485 form, or a form that contains identical information to the CMS-485, and all applicable forms shall be complete; and

   d. For ongoing telehealth, the agency shall include documentation on how telehealth data has been used to manage the client's care, if the client has been using Home Health Telehealth services.

**8.520.9 Reimbursement**

**8.520.9.A. Rates of Reimbursement:** Payment for Home Health Services is the lower of the billed charges or the maximum unit rate of reimbursement.

1. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed the daily maximum as designated by the Department and in alignment with the Legislative Budget.

2. The maximum daily reimbursement includes reimbursement for nursing visits, home health CNA visits, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof."

**8.520.9.B. Special Reimbursement Conditions**

1. Total reimbursement by the Department combined with third party liability and Medicare crossover claims shall not exceed Medicaid rates.

2. When Home Health Agencies provide Home Health Services in accordance with these regulations to Clients who receive Home and Community-based Services for the Developmentally Disabled (HCBS-DD), the Home Health Agency is reimbursed:

   a. Under normal procedures for home health reimbursement if the Client resides in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or in IRSS host homes and settings; or

   b. By the group home provider, if the Client resides in a GRSS, because the provider has already received Medicaid funding for the Home Health Services and is responsible for payment to the Home Health Agency.

3. Acute Home Health Services for Medicaid HMO Clients are the responsibility of the Medicaid HMO, including Clients who are also HCBS recipients.

4. Services for a dual eligible Client shall be submitted first to Medicare for reimbursement. All Medicare requirements shall be met and administrative processes exhausted prior to any dual eligible Client's claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except for the specific services listed in Section 8.520.0.E.4.a below for Clients which meet the criteria listed in Section 8.520.9.E.4.b below.

a. A Home Health Agency may bill only Medicaid without first billing Medicare if both of the following are true:

i) The services below are the only services on the claim:

1) Pre-pouring of medications;

2) CNA services;

3) Occupational therapy services when provided as the sole skilled service; or

4) Routine laboratory draw services.

ii) The following conditions apply:

1) The Client is stable;

2) The Client is not experiencing an acute episode; and

3) The Client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

b. The Home Health Agency shall maintain clear documentation in the Client's record of the conditions and services that are billed to Medicaid without first billing Medicare.

c. A Home Health Change of Care Notice or Advance Beneficiary Notice of Non-Coverage shall be filled out as prescribed by Medicare.

5. Services for a dually eligible long-term home health Client who has an acute episode shall be submitted first to Medicare for reimbursement. Medicaid may be billed if payment is denied by Medicare as a non-covered benefit and the service is a Medicaid benefit, or when the service meets the criteria listed in Section 8.520.9.E.4 above.

6. If both Medicare and Medicaid reimburse for the same visit or service provided to a Client in the same episode, the reimbursement is considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

a. Home Health Agencies shall return any payment made by Medicaid for such visit or service to the Department within sixty (60) calendar days of receipt of the duplicate payment.

**8.520.9.C. Reimbursement for Supplies**

1. A Home Health Agency shall not ask a Client to provide any supplies. A request for supplies from a Client may constitute a violation of Section 8.012, PROVIDERS PROHIBITED FROM COLLECTING PAYMENT FROM RECIPIENTS.

2. Supplies other than those required for practice of universal precautions which are used by the Home Health Agency staff to provide Home Health Services are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the physician as a benefit to the Client under Section 8.590, DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLES.

3. Supplies used for the practice of universal precautions by the Client's family or other informal caregivers are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the physician as a benefit to the Client under Section 8.590, DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES.

**8.520.9.D. Restrictions**

1. When the Client has Medicare or other third-party insurance, Home Health claims to Medicaid will be reimbursed only if the Client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.

2. When an agency provides more than one employee to render a service, in which one employee is supervising or instructing another in that service, the Home Health Agency shall only bill and be reimbursed for one employee's visit or units.

3. Any visit made by a nurse or therapist to simultaneously serve two or more Clients residing in the same household shall be billed by the Home Health Agency as one visit only, unless services to each Client are separate and distinct. If two or more Clients residing in the same household receive Medicaid CNA services, the services for each Client shall be documented and billed separately for each Client.

4. No more than one Home Health Agency may be reimbursed for providing Home Health Services during a specific plan period to the same Client, unless the second agency is providing a Home Health Service that is not available from the first agency. The first agency shall take responsibility for the coordination of all Home Health Services. Home and Community-based Services, including personal care, are not Home Health Services.

5. Improper Billing Practices: Examples of improper billing include, but are not limited to:

    a. Billing for visits without documentation to support the claims billed. 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 Client's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.076.2;

    b. Billing for unnecessary visits, or visits that are unreasonable in number, frequency or duration;

    c. Billing for CNA visits in which no skilled tasks were performed and documented;

    d. Billing for skilled tasks that were not medically necessary;

    e. Billing for Home Health Services provided at locations other than an eligible place of service, except EPSDT services provided with prior authorization; and

    f. Billing of personal care or homemaker services as Home Health Services.

6. A Home Health Agency that are also certified as a personal care/homemaker provider shall ensure that neither duplicate billing nor unbundling of services occurs in billing for Home Health Services and HCBS personal care services. Examples of duplicate billing and unbundling of services include:

    a. One employee makes one visit, and the agency bills Medicaid for a CNA visit, and also bills all of the hours as HCBS personal care or homemaker.

b. One employee makes one visit, and the agency bills for one CNA visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 1 hour plus the number of hours billed for HCBS personal care and homemaker.

c. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of CNA and personal care or homemaker services.

7. The Department may take action against the offending Home Health Agency, including termination from participation in Colorado Medicaid in accordance with 10 C.C.R. 2505-10, Section 8.076.

**8.520.10 Compliance Monitoring Reviews**

**8.520.10.A. General Requirements**

1. Compliance monitoring of Home Health Services may be conducted by state and federal agencies, their contractors and law enforcement agencies in accordance with 10 C.C.R. 2505-10, Section 8.076.

2. Home Health Agencies shall submit or produce all requested documentation in accordance with 10 C.C.R. 2505-10, Section 8.076.

3. Physician-signed Plans of Care shall include nursing or therapy assessments, current clinical summaries and updates for the Client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485. All sections of the form shall be completed. All therapy services provided shall be included in the Plan of Care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency.

4. Provider records shall document the nature and extent of the care actually provided.

5. Unannounced site visits may be conducted in accordance with Section 25.5-4-301(14)(b) C.R.S.

6. Home Health Services which are duplicative of any other services that the Client has received funded by another source or that the Client received funds to purchase shall not be reimbursed.

7. Services which total more than twenty-four hours per day of care, regardless of funding source shall not be reimbursed.

8. Billing for visits or contiguous units which are longer than the length of time required to perform all the tasks prescribed on the care plan shall not be reimbursed.

9. Home Health Agencies shall not bill Clients or families of Client for any services for which Medicaid reimbursement is recovered due to administrative, civil or criminal actions by the state or federal government.

**8.520.11 Denial, Termination, or Reduction in Services**

8.520.11.A. When services are denied, terminated, or reduced by action of the Home Health Agency, the Home Health Agency shall notify the Client.

8.520.11.B. Termination of services to Clients still medically eligible for Coverage of Medicaid Home Health Services:

1. When a Home Health Agency decides to terminate services to a client who needs and wants continued Home Health Services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the Home Health Agency shall give the client, or the client's designated representative/legal guardian, written advance notice of at least 30 business days. The Ordering Practitioner and the Department's Home Health Policy Specialist shall also be notified.

2. Written notice to the Client, or Client's designated representative/legal guardian shall be provided in person or by certified mail and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services

3. The agency shall make a good faith effort to assist the Client in securing the services of another agency.

4. If there is indication that ongoing services from another source cannot be arranged by the end of the advance notice period, the terminating agency shall ensure Client safety by making referrals to appropriate case management agencies or County Departments of Social Services; and the attending physician shall be informed.

5. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the Client, Home Health Agency, staff, or when the Client has begun to receive Home Health Services through a Medicaid HMO.

## 8.535 PEDIATRIC PERSONAL CARE SERVICES

8.535.1 Pediatric Personal Care Services are provided in accordance with the provisions of Appendix A, which sets forth the coverage standards for the benefit.

### 8.535.2 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

#### 8.535.2.A DEFINITIONS

1. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of pediatric personal care services. For the purposes of this rule, the base wage shall be $15.00 effective January 1, 2022.

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

3. 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 for personal pediatric care.

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 8.535.2.D.

6. 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.

7. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of pediatric personal care services. For purposes of this rule, the per diem wage shall apply to Direct Care Workers of residential service providers.

**8.535.2.B QUALIFYING SERVICES**

1. Effective January 1, 2022, the Department will increase reimbursement rates for pediatric personal care services. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher.

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 effective January 1, 2022 by the percent of the Department's January 1, 2022 reimbursement rate increase.

**8.535.2.C 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 8.535.2.D.

2. Providers shall notify Direct Care Workers who are affected by the base wage requirement each fiscal year up to and including Fiscal Year 2024-2025.

    a. Provider shall utilize the Department approved letter.

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. On or before June 30, 2022, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

    a. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

        i. Full-time or part-time employment status.

ii. Whether the Direct Care Worker is an Employee or Independent Contractor.

iii. Employee start date if after January 1, 2022.

iv. Direct Care Workers' hourly base wage as of November 1, 2021 and current hourly base wage.

v. Current service(s) provided by each employee.

b. IRSS Providers and/or Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

i. Full-time or part-time employment status.

ii. Whether the Direct Care Worker is an Employee or Independent Contractor.

iii. Employee start date if after January 1, 2022.

iv. Direct Care Workers' per diem wage as of December 1, 2021 and per diem wage as of January 1, 2022.

5. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the pediatric personal care 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

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

**8.535.2.D REPORTING AND AUDITING REQUIREMENTS**

1. 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 services listed in Section 8.535.2.B 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.

3. 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.

4. If a plan of correction is requested by the Department, the Provider shall have forty-five (45) business days from the date of the request to respond. 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 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.

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.

## 8.540 PRIVATE DUTY NURSING SERVICES

### 8.540.1 DEFINITIONS

Family/In-Home Caregiver means an unpaid individual who assumes a portion of the client's Private Duty Nursing care in the home, when Home Health Agency staff is not present. A Family/In-Home Caregiver may either live in the client's home or go to the client's home to provide care.

Home Health Agency means a public agency or private organization or part of such an agency or organization which is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act.

Plan of Care means a care plan developed by the Home Health Agency in consultation with the client, that has been ordered by the attending physician for provision of services to a client at his/her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements at 42 C.F.R. 484.18.

Private Duty Nursing (PDN) means face-to-face Skilled Nursing that is more individualized and continuous than the nursing care that is available under the home health benefit or routinely provided in a hospital or nursing facility.

Re-Hospitalization means any hospital admission that occurs after the initial hospitalization for the same condition.

Skilled Nursing means services provided under the licensure, scope and standards of the Colorado Nurse Practice Act, Title 12 Article 38 of the Colorado Revised Statutes, performed by a registered nurse (RN) under the direction of a physician, or a licensed practical nurse (LPN) under the supervision of a RN and the direction of a physician.

Technology Dependent means a client who:

a. Is dependent at least part of each day on a mechanical ventilator; or

b. Requires prolonged intravenous administration of nutritional substances or drugs; or

c. Is dependent daily on other respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support or tube feedings when they are not intermittent.

### 8.540.2 BENEFITS

8.540.2.A. Beginning November 1, 2021, providers must submit a prior authorization request for all new PDN services. For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request in accordance with the schedule provided in Section 8.540.7.G.

8.540.2.B. A pediatric client may be approved for up to 24 hours per day of PDN services if the client meets the URC medical necessity criteria. PDN for pediatric clients is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable.

1. The URC shall determine the number of appropriate pediatric PDN hours by considering age, stability, need for frequent suctioning and the ability to manage the tracheostomy.

2. The URC shall consult with the Home Health Agency and the attending physician or primary care physician, to provide medical case management with the goal of resolving the problem that precipitated the need for extended PDN care of more than 16 hours.

3. The URC shall consider combinations of technologies and co-morbidities when making medical criteria determinations.

8.540.2.C. Twenty-four hour care may be approved for pediatric clients during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year.

8.540.2.D. Adult clients may be approved up to 23 hours per day when determined medically necessary.

8.540.2.E. A client who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the client's activities of daily living take him or her away from the home. The total hours authorized shall not exceed the hours that would have been authorized if the client received all care in the home.

**8.540.3 BENEFIT LIMITATIONS**

8.540.3.A. A client who meets both the eligibility requirements for PDN and home health shall be allowed to choose whether to receive care under PDN or under home health. The client may choose a combination of the two benefits if the care is not duplicative and the resulting combined care does not exceed the medical needs of the client.

8.540.3.B. Hours of PDN shall never exceed the hours per day that the URC determines are medically necessary.

**8.540.4 ELIGIBILITY**

8.540.4.A. A client shall be eligible for PDN services when the client is:

1. Technology Dependent.

2. Medically stable, except for acute episodes that can be safely managed under PDN, as determined by the attending physician.

3. Able to be safely served in their home by a home health agency under the agency requirements and limitations of the PDN benefit and with the staff services available.

4. Not residing in a nursing facility or hospital at the time PDN services are delivered.

5. Eligible for Medicaid in a non-institutional setting.

6. Able to meet one of the following medical criteria:

   a. The client needs PDN services while on a mechanical ventilator.

   b. The client needs PDN services for ventilator weaning during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions from tracheostomy, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%.

c. The pediatric client needs PDN services after tracheostomy decannulation during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions, not using auxiliary muscles for breathing, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%.

d. The pediatric client needs PDN services during the hours spent on continuous positive airway pressure (C-PAP), until the client is medically stable.

e. The pediatric client needs PDN services for oxygen administration only if there is documentation of rapid desaturation without the oxygen as evidenced by a drop in pulse oximeter readings below 85% within 15-20 minutes, and/or respiratory rate increases, and/or heart rate increases and/or skin color changes. If oxygen is the only technology present, the URC shall review for an individual determination of medical necessity for PDN.

f. The pediatric client needs PDN services during the hours required for prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids.

g. The URC shall consider combinations of technologies and co-morbidities when making medical determinations for the following medical conditions:

i) A pediatric client with tube feedings, including nasogastric tube, gastric tube, gastric button and jejunostomy tube, whether intermittent or not, who is not on mechanical ventilation.

ii) An adult client with a tracheostomy, who is not on mechanical ventilation or being weaned from mechanical ventilation.

iii) An adult client with a tracheostomy decannulation, who is not on mechanical ventilation or being weaned from mechanical ventilation.

iv) An adult client who has Continuous Positive Airway Pressure (C-PAP), but is not on mechanical ventilation or being weaned from mechanical ventilation.

v) An adult client with oxygen supplementation, who is not on mechanical ventilation or being weaned from mechanical ventilation.

vi) An adult client receiving prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids who is not on mechanical ventilation or being weaned from mechanical ventilation.

vii) An adult client with tube feedings that are continuous, including nasogastric tube, gastric tube, gastric button and jejunostomy tube who is not on mechanical ventilation nor being weaned from mechanical ventilation.

7. The medical judgment of the attending physician and the URC shall be used to determine if the criteria are met wherever the medical criteria are not defined by specific measurements.

**8.540.5 APPLICATION PROCEDURES**

8.540.5.A. The hospital discharge planner shall coordinate with the Home Health Agency to:

1. Refer the client or the client's authorized representative to appropriate agencies for Medicaid eligibility determination in the non-institutional setting, as needed.

2. Plan for the client's hospital discharge by:

   a. Arrange services with the Home Health Agency, medical equipment suppliers, counselors and other health care service providers as needed.

   b. Coordinate, in conjunction with the physician and the Home Health Agency, a home care plan that is safe and meets program requirements.

   c. Advise the Home Health Agency of any changes in medical condition and care needs.

   d. Ensure that the client, family and caregivers are educated about the client's medical condition and trained to perform the home care.

3. Submit an application to determine PDN eligibility to the URC if the client is hospitalized when services are first requested or ordered.

8.540.5.B. The Home Health Agency case coordinator shall submit the application for PDN services to the URC if the client is not in the hospital.

8.540.5.C. An application may be submitted up to six months prior to the anticipated need for PDN services. Updated medical information shall be sent to the URC as soon as the service start date is known.

8.540.5.D. The application shall be submitted on a Department PDN application form. Any medical information necessary to determine the client's medical need shall be included with the application form.

8.540.5.E. If the client has other insurance that has denied PDN coverage, a copy of the denial letter, explanation of benefits or the insurance policy shall be included with the application.

8.540.5.F. If services are being requested beyond the 16 hour per day benefit as a result of an EPSDT medical screening, written documentation of those screening results shall be included with the application. The EPSDT claim form shall not meet this requirement.

8.540.5.G. The URC nurse reviewer shall review applications for PDN according to the following procedures:

1. Review the information provided and apply the medical criteria.

2. Return the application to the submitting party for more information within seven working days of receipt of an incomplete application if the application is not complete.

3. Approve the application, or refer the application to the URC physician reviewer within 10 working days of receipt of the complete application. The physician reviewer shall have 10 working days to determine approval or denial of the application for PDN.

4. Notify the client or the client's designated representative and the submitting party of application approval.

5. Notify the client, the client's designated representative and the submitting party of the client's appeal rights by placing written notification in the mail within one working day of a denial decision.

8.540.5.H. Clients who are approved and who subsequently discontinue PDN for any reason do not need an application to request resumption of PDN services within six months of discontinuing PDN services. Services may be resumed upon approval of a Prior Authorization Request (PAR).

**8.540.6 PROVIDER REQUIREMENTS**

8.540.6.A. A certified Home Health Agency may be authorized to provide PDN services if the agency meets all of the following:

1. Employs nursing staff currently licensed in Colorado with experience in providing PDN or care to Technology-Dependent persons.

2. Employs nursing personnel with documented skills appropriate for the client's care.

3. Employs staff with experience or training, in providing services to the client's particular demographic or cultural group.

4. Coordinates services with a supplemental certified Home Health Agency, if necessary, to meet the staffing needs of the client.

5. Requires the primary nurse and other personnel to spend time in the hospital prior to the initial hospital discharge or after Re-Hospitalization, to refine skills and learn individualized care requirements.

6. Provides appropriate nursing skills orientation and on going in-service education to nursing staff to meet the client's specific nursing care needs.

7. Requires nursing staff to complete cardio pulmonary resuscitation (CPR) instruction and certification at least every two years.

8. Provides adequate supervision and training for all nursing staff.

9. Designates a case coordinator who is responsible for the management of home care which includes the following:

   a. Assists with the hospital discharge planning process by providing input and information to, and by obtaining information from, the hospital discharge planner and attending physician regarding the home care plan.

   b. Assesses the home prior to the initial hospital discharge and on an ongoing basis for safety compliance.

   c. Submits an application for PDN to the URC if the client is not in the hospital at the time services are requested.

   d. Refers the client or the client's designated representative to the appropriate agency for Medicaid eligibility determination, if needed.

e. Ensures that a completed PAR is submitted to the URC prior to the start of care and before the previous PAR expires.

f. Provides overall coordination of home services and service providers.

g. Involves the client and Family/In Home Caregiver in the plan for home care and the provision of home care.

h. Assists the client to reach maximum independence.

i. Communicates changes in the case status with the attending physician and the URC on a timely basis, including changes in medical conditions and/or psychological/social situations that may affect safety and home care needs.

j. Assists with communication and coordination between the service providers supplementing the primary Home Health Agency, the primary care physician, specialists and the primary Home Health Agency as needed.

k. Makes regular on-site visits to monitor the safety and quality of home care, and makes appropriate referrals to other agencies for care as necessary.

l. Ensures that complete and current care plans and nursing charts are in the client's home at all times. Charts shall include interim physician orders, current medication orders and nursing notes. Records of treatments and interventions shall clearly show compliance with the times indicated on the care plans.

m. Communicates with Single Entry Point or other case managers as needed regarding service planning and coordination.

10. Makes and documents the efforts made to resolve any situation that triggers a discontinuation or refusal to provide services prior to discontinuation or refusal to provide services.

11. Documents that the Family/In-Home Caregiver:

a. Is able to assume some portion of the client's care.

b. Has the specific skills necessary to care for the client.

c. Has completed CPR instruction or certification and/or training specific to the client's emergency needs prior to providing PDN services.

d. Is able to maintain a home environment that allows for safe home care, including a plan for emergency situations.

e. Participates in the planning, implementation and evaluation of PDN services.

f. Communicates changes in care needs and any problems to health care providers and physicians as needed.

g. Works toward the client’s maximum independence, including finding and using alternative resources as appropriate.

h. Has notified power companies, fire departments and other pertinent agencies, of the presence of a special needs person in the household.

12. Performs an in-home assessment and documents that the home meets the following safety requirements:

    a. Adequate electrical power including a back up power system.

    b. Adequate space for equipment and supplies.

    c. Adequate fire safety and adequate exits for medical and other emergencies.

    d. A clean environment to the extent that the client's life or health is not at risk.

    e. A working telephone available 24 hours a day.

8.540.6.B. The Home Health Agency shall coordinate with the client's attending physician to:

1. Determine that the client is medically stable, except for acute episodes that can be managed under PDN, and that the client can be safely served under the requirements and limitations of the PDN benefit.

2. Cooperate with the URC in establishing medical eligibility.

3. Prescribe a plan of care at least every 60 days.

4. Coordinate with any other physicians who are treating the client.

5. Communicate with the Home Health Agency about changes in the client's medical condition and care, especially upon discharge from the hospital.

6. Empower the client and the Family/In-Home Caregiver by working with them and the Home Health Agency to maximize the client's independence.

**8.540.7 PRIOR AUTHORIZATION PROCEDURES**

8.540.7.A. The Home Health Agency shall submit the initial PAR to the URC prior to the start of PDN.

8.540.7.B. The PAR shall be approved for up to six months for a new client and up to one year for ongoing care depending upon prognosis for improvement or recovery, according to the medical criteria.

8.540.7.C. The PAR information shall:

1. Be submitted on a Department PAR form. A copy of the current plan of care shall be included. For new clients admitted to PDN directly from the hospital, a copy of the transcribed verbal physician orders may be substituted for the plan of care if the client has been approved for admission to PDN.

2. Be submitted with the plan of care that:

    a. Is on the CMS 485 form, or a form that is identical in format to the CMS 485. All sections of the form relating to nursing needs shall be completed.

    b. Includes a signed nursing assessment, a current clinical summary or update of the client's condition and a physician's plan of treatment. A hospital discharge summary shall be included if there was a hospitalization since the last PAR.

c. Indicates the frequency and the number of times per day that all technology-related care is to be administered. Ranges and a typical number of hours needed per day are required. The top of the range is the number of hours ordered by the physician as medically necessary. The lower number is the amount of care that may occur due to family availability or choice, holidays or vacations or absence from the home.

d. Includes a process by which the client receiving services and support may continue to receive necessary care, which may include respite care, if the client's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or the caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.

3. Include an explanation for the decision to use an LPN. This decision shall be at the discretion of the attending physician, the Home Health Agency and the RN responsible for supervising the LPN.

4. Cover a period of up to one year depending upon medical necessity determination.

5. Include only the services of PDN-RN and/or PDN-LPN. If any other services are included on the PAR, the URC shall return the PAR without processing it.

6. Be submitted within five working days of the change as a revision when a change in the plan of care results in an increase in hours. A revised plan of care or a copy of the physician's verbal orders for the increased hours including the effective date shall be included with the PAR form.

7. Be submitted to decrease the number of hours for which the client may be eligible when a change in the client's condition occurs which could affect the client's eligibility for PDN, or decrease the number of hours for which the client may be eligible. The agency shall notify the URC within one working day of the change. Failure to notify the URC may result in recovery of inappropriate payments, if any, from the Home Health Agency.

8. Be submitted within five working days of the discharge or death, as a revised PAR when a client is discharged or dies prior to the end date of the PAR. The revision is to the end date and the number of service units.

8.540.7.D. The URC shall review PARs according to the following procedures:

1. Review information provided and apply the medical criteria as described herein.

2. Return an incomplete PAR to the Home Health Agency for correction within ten working days of receipt.

3. Approve the PAR, or refer the PAR to the URC physician reviewer, within 10 working days of receipt of the complete PAR.

4. Process physician review referrals and approve, partially approve, or deny the PAR within 10 working days of receipt from the nurse reviewer. The URC physician reviewer shall attempt to contact the attending physician or the primary care physician for more information prior to a denial or reduction in services.

5. Provide written notification to the client or client's designated representative and submitting party of all PAR denials and the client's appeal rights, within one working day of the decision.

6. Approve subsequent continued stay PARs that have been to physician review without referral, if the client's condition and the requested hours have not changed.

7. Notify the Department of all extraordinary PDN services approved as a result of an EPSDT screen.

8. Notify the submitting party of all PAR approvals.

9. Expedite PAR reviews in situations where adhering to the time frames above would seriously jeopardize the client's life or health.

8.540.7.E. No services shall be approved for dates of service prior to the date the URC receives a complete PAR. PAR revisions for medically necessary increased services may be approved back to the day prior to receipt by the URC if the revised PAR was received within five working days of the increase in services. Facsimiles may be accepted.

8.540.7.F. The URC nurse reviewer may attend hospital discharge planning conferences, and may conduct on site visits to each client at admission and every six months thereafter.

8.540.7.G. For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request (PAR) in accordance with the schedule in Sections 8.540.7.G.1-10. When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client.

1. Ten percent (10%) of PARs must be submitted by November 30, 2021;

2. An additional 10% of PARs must be submitted by December 31, 2021;

3. An additional 10% of PARs must be submitted by January 31, 2022;

4. An additional 10% of PARs must be submitted by February 28, 2022;

5. An additional 10% of PARs must be submitted by March 31, 2022;

6. An additional 10% of PARs must be submitted by April 30, 2022;

7. An additional 10% of PARs must be submitted by May 31, 2022;

8. An additional 10% of PARs must be submitted by June 30, 2022;

9. An additional 10% of PARs must be submitted by July 31, 2022;

10. The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.

**8.540.8 REIMBURSEMENT**

8.540.8.A. No services shall be authorized or reimbursed if hours of service, regardless of funding source, total more than 24 hours per day.

8.540.8.B. No services shall be reimbursed if the care is duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health or other insurance.

8.540.8.C. Approval of the PAR by the URC shall authorize the Home Health Agency to submit claims to the Medicaid fiscal agent for authorized PDN services provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the provider's use of correct billing procedures.

8.540.8.D. No services shall be reimbursed for dates of service prior to the PAR start date as authorized by the URC.

8.540.8.E. Skilled Nursing services under the PDN shall be reimbursed in units of one hour, at the provider’s usual and customary charge or the maximum Medicaid allowable rates established by the Department, whichever is less. Units of one hour may be billed for RN, LPN, RN group rate (registered nurse providing PDN to more than one client at the same time in the same setting), LPN group rate (licensed practical nurse providing PDN to more than one client at the same time in the same setting) or Blended RN/LPN rate (group rate by request of the Home Health Agency only).

## 8.550 HOSPICE BENEFIT

### 8.550.1 DEFINITIONS

A. Alternative Care Facility (ACF) means an assisted living residence that is enrolled as a Medicaid provider.

B. Assisted Living Residence means an assisted living residence as defined in 6 CCR 1011-1 Chapter 7.

C. Benefit Period means a period during which the Client has made an Election to receive hospice care defined as one or more of the following:

1. An initial 90-day period.

2. A subsequent 90-day period.

3. An unlimited number of subsequent 60-day periods.

The periods of care are available in the order listed and may be Elected separately at different times.

D. Certification means that the Client's attending physician and/or the Hospice Provider's medical director have affirmed that the Client is Terminally Ill.

E. Client Record means a medical file containing the Client's Election of Hospice, eligibility documentation, and other medical records.

F. Department means the Colorado Department of Health Care Policy and Financing. The Department is designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

G. Election/Elect means the Client's written expression to choose Hospice care for Palliative and Supportive Medical Services. Home Care Services means Hospice Services that are provided primarily in the Client's home but may be provided in a residential facility and/or licensed or certified health care facility.

H. Hospice means a centrally administered program of palliative, supportive, and Interdisciplinary Team services providing physical, psychological, sociological, and spiritual care to Terminally Ill Clients and their families.

I. Hospice Provider means a Medicaid and Medicare-certified Hospice provider.

J. Hospice Services means counseling, certified nurse aide, personal care worker, homemaker, nursing, physician, social services, physical therapy, occupational therapy, speech therapy, and trained volunteer services.

K. Interdisciplinary Team means a group of qualified individuals, consisting of at least a physician, registered nurse, clergy, counselors, volunteer director or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice Clients and their families.

L. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) means a care facility which is designed, and functions, to meet the needs of four or more individuals with developmental disabilities, or related conditions, who require twenty-four-hour active treatment services.

M. Medical Necessity or Medically Necessary is defined in Section 8.076.1.8.

N. Palliative and Supportive Medical Services means those services and/or interventions which are not curative, but which produce the greatest degree of relief from the symptoms of the Terminal Illness.

O. Room and Board includes a place to live and the amenities that come with that place to live, including but not limited to provision of:

1. Meals and additional nutritional requirements, as prescribed;

2. Performance of personal care services, including assistance with activities of daily living;

3. Provision of social activities;

4. Equipment necessary to safely care for the Client and to transport the Client, as necessary;

5. Administration of medication;

6. Maintenance of the cleanliness of a Client's room; and

7. Supervision and assistance in the use of durable medical equipment and prescribed therapies.

P. Terminally Ill/Terminal Illness means a medical prognosis of life expectancy of nine months or less, should the illness run its normal course.

**8.550.2 INITIATION OF HOSPICE**

**8.550.2.A. Certification**

The Hospice Provider must obtain Certification that a Client is Terminally Ill in accordance with the following procedures:

1. For the first Benefit Period of Hospice coverage or re-Election following revocation or discharge from the Hospice benefit, the Hospice Provider must obtain:

a. A written Certification signed by either the Hospice Provider's medical director or the physician member of the Interdisciplinary Team and the Client's attending physician. The written Certification must be obtained and placed in the Client Record within two calendar days after Hospice Services are initiated. The written Certification must include:

i) A statement of the Client's life expectancy including diagnosis of the terminal condition, other health conditions whether related or unrelated to the terminal condition, and current clinically relevant information supporting the diagnoses and prognosis for life expectancy and Terminal Illness;

ii) The approval of the Client's physician(s) for Hospice Services; and

iii) The approval of the Hospice Provider of Hospice Services for the Client.

b. A verbal Certification statement from either Hospice Provider's medical director or the physician member of the Interdisciplinary Team and the Client's attending physician, if written certification cannot be obtained within two calendar days after Hospice Services are initiated. The verbal Certification must be documented, filed in the Client Record, and include the information described at Section 8.550.2.A.1.a.i, ii, and iii. Written Certification documentation must follow and be filed in the Client Record prior to submitting a claim for payment.

2. At the beginning of each subsequent Benefit Period, the Hospice Provider must obtain a written re-Certification prepared by either the attending physician, the Hospice Provider's medical director or the physician member of the Interdisciplinary Team.

**8.550.2.B. Election Procedures**

1. An Election of Hospice Services continues as long as there is no break in care and the Client remains with the Elected Hospice Provider.

2. If a Client Elects to receive Hospice Services, the Client or Client representative must file an Election statement with the Hospice Provider that must be maintained in the Client's Record and must include:

a. Designation of the Hospice Provider. A Client must choose only one Hospice Provider as the designated Hospice Provider;

b. Acknowledgment that the Client or Client representative has a full understanding of the palliative rather than curative nature of Hospice Services;

c. Designation by the Client or Client representative of the effective date for the Election period. The first day of Hospice Services must be the same or a later date;

d. An acknowledgement that for the duration of the Hospice Services, the Client waives all rights to Medicaid payments for the following services:

i) Hospice Services provided by a Hospice Provider other than the provider designated by the Client (unless provided under arrangements made by the designated Hospice Provider);

ii) Any Medicaid services that are related to the treatment of the terminal condition for which Hospice Services were Elected, or a related condition, or that are equivalent to Hospice Services, except for services that are:

1) Provided by the designated Hospice Provider;

2) Provided by another Hospice Provider under arrangements made by the designated Hospice Provider;

3) Provided by the individual's attending physician if that physician is not an employee of the designated Hospice Provider or receiving compensation from the Hospice Provider for those services; and,

4) Services provided to Clients ages 20 and under.

e. A signature, physical or digital, of either the Client or Client representative, as allowed by Colorado law.

3. A Client or client representative may revoke the Election of Hospice Services by filing a signed statement of revocation with the Hospice Provider. The statement must include the effective date of the revocation. The Client must not designate an effective date earlier than the date that the revocation is made. Revocation of the Election of Hospice Services ends the current Hospice Benefit Period.

a. Clients who are dually eligible for Medicare and Medicaid must revoke the Election of Hospice Services under both programs.

4. The Client may resume coverage of the waived benefits as described at 8.550.2.B.2.d. upon revoking the Election of Hospice Services.

5. The Client may re-Elect to receive Hospice Services at any time after the services are discontinued due to discharge, revocation, or loss of Medicaid eligibility, should the Client thereafter become eligible.

6. The Client may change the designation of the Hospice Provider once each Benefit Period. A change in designation of Hospice Provider is not a revocation of the Client's Hospice Election. To change the designation of the Hospice Provider, the Client must file a statement with the current and new provider which includes:

a. The name of the Hospice Provider from which the Client is receiving care and the name of the Hospice Provider from which he or she plans to receive care;

b. The date the change is to be effective; and

c. The signature, physical or digital, of the Client or Client representative, as allowed by Colorado law.

## 8.550.3 HOSPICE RELATED TO HCBS WAIVERS

### 8.550.3.A. Provision of Services

1. Hospice Services may be provided to a client who is enrolled in one of the Colorado Medicaid home and community-based services (HCBS) waivers, including the children with life limiting illness waiver.

2. HCBS waiver services may be provided for conditions unrelated to the client's terminal diagnosis. For children ages 20 and under, HCBS waivers services may be provided for conditions related or unrelated to the client's terminal diagnosis.

3. HCBS waiver services may also be provided to the client when these services are not duplicative of the services that are the responsibility of the Hospice Provider. HCBS waivers are those waivers as defined at Sections 8.500 through 8.599.

**8.550.3.B. Waiver Coordination**

1. The Hospice Provider must notify the HCBS waiver case manager or support coordinator of the client's Election of Hospice Services and the anticipated start date.

2. The Hospice Provider must coordinate Hospice Services and HCBS waiver services with the HCBS waiver case manager or support coordinator and must document coordination of these services in the Client Record. Documentation must include:

   a. Identification of the Hospice Services that will be provided;

   b. Identification of the HCBS waiver services that will be provided under the waiver; and

   c. Integration of Hospice Services and HCBS waiver services in the Hospice plan of care.

3. The Hospice Provider must invite the HCBS waiver case manager or support coordinator to participate in the Interdisciplinary Team meetings for the client when possible.

**8.550.4 BENEFITS**

**8.550.4.A. Hospice Standard of Care**

1. Hospice Services must be reasonable and Medically Necessary for the palliation or management of the Terminal Illness as well as any related condition, but not for the prolongation of life.

2. Clients ages 20 and under are exempt from the restriction on care for the prolongation of life.

**8.550.4.B. Covered Services**

Covered Hospice Services include, but are not limited to:

1. Nursing care provided by or under the supervision of a registered nurse.

2. Medical social services provided by a qualified social worker or counselor under the direction of a physician.

3. Counseling services, including dietary and spiritual counseling, provided to the Terminally Ill client and his or her family members or other persons caring for the client.

4. Bereavement counseling delivered through an organized program under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the client).

5. Short-term general inpatient care necessary for pain control and/or symptom management up to 20 percent of total Hospice Service days.

6. Short-term inpatient care of up to five consecutive days per Benefit Period to provide respite for the client's family or other home caregiver.

7. Medical appliances and supplies, including pharmaceuticals and biologicals which are used primarily for symptom control and relief of pain related to the Terminal Illness.

8. Intermittent certified nurse aide services available and adequate in frequency to meet the needs of the client. Certified nurse aides practice under the general supervision of a registered nurse. Certified nurse aide services may include unskilled personal care and homemaker services that are directly related to a visit.

9. Occupational therapy, physical therapy, and speech-language pathology appropriate to the terminal condition, provided for the purposes of symptom control or to enable the terminal client to maintain activities of daily living and basic functional skills.

10. Trained volunteer services.

11. Any other service that is specified in the client's plan of care as reasonable and Medically Necessary for the palliation and management of the client's Terminal Illness and related conditions and for which payment may otherwise be made under Medicaid.

**8.550.4.C. [Expired 05/15/2014 per House Bill 14-1123]**

**8.550.4.D. Non-Covered Services**

Services not covered as part of the Hospice Benefit include, but are not limited to:

1. Services provided before or after the Hospice Election period.

2. Services of the client's attending or consulting physician that are unrelated to the terminal condition which are not waived under the Hospice Benefit.

3. Services or medications received for the treatment of an illness or injury not related to the client's terminal condition.

4. Services which are not otherwise included in the Hospice benefit, such as electronic monitoring, non-medical transportation, and home modification under a Home and Community-Based Services (HCBS) program.

5. Personal care and homemaker services beyond the scope provided under Hospice Services which are contiguous with a certified nurse aide visit.

6. Hospice Services covered by other health insurance, such as Medicare or private insurance.

7. Hospice Services provided by family members.

**8.550.4.E. Prior Authorization**

Prior authorization is not required for Hospice Services.

**8.550.4.F. Intermittent Home Health Certified Nurse Aide Services**

Intermittent home health certified nurse aide services may be utilized with Hospice Services coordination for treatment of conditions that are not related to the terminal diagnosis and are not meant to cure the client's terminal condition. Children under 20 are exempt from this requirement.

**8.550.4.G. Included Activities**

Medicaid does not separately reimburse for activities that are the responsibility of the Hospice Provider, including coordination of care for the client and bereavement counseling.

**8.550.5 ELIGIBLE PLACE OF SERVICE**

**8.550.5.A. Place of Service**

1. Hospice Services are provided in a Client's place of residence, which includes:

   a. A residence such as, but not limited to, a house, apartment or other living space that the Client resides within;

   b. An assisted living residence including an Alternative Care Facility;

   c. A temporary place of residence such as, but not limited to, a relative's home or a hotel. Temporary accommodations may include homeless shelters or other locations provided for a Client who has no permanent residence to receive Hospice Services;

   d. Other residential settings such as a group home or foster home;

   e. A licensed Hospice Facility or Nursing Facility (NF);

   f. An Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID), or Nursing Facility (NF), unless the Client is in a waiver program which does not allow residency in an ICF/IID or NF; or

   g. An Individual Residential Services & Supports (IRSS) or a Group Residential Services & Supports (GRSS) host home setting.

2. For Hospice Clients residing in a NF, ICF/IID, IRSS or GRSS, the Client must meet both the Hospice requirements and the requirements for receipt of those Medicaid-covered services.

3. Colorado Medicaid does not reimburse Hospice Services provided in hospitals except when the Client has been admitted for respite services.

**8.550.5.B. Hospice Setting Requirements**

1. Nursing Facilities:

   a. Hospice Services may be provided to a Client who resides in a Medicaid participating NF.

   b. When a Client residing in a NF Elects Hospice Services, the Client is considered a Hospice Client and is no longer a NF Client with the exception of the facility's responsibility to provide Room and Board to the Client.

   c. In order for a Client to receive Hospice Services while residing in a NF, the Hospice Provider must:

      i) Notify the NF that the Client has Elected Hospice and the expected date that Hospice Services will commence;

ii) Ensure the NF concurs with the Hospice plan of care;

iii) Ensure the NF is Medicaid certified; and

iv) Execute a written agreement with the NF, which must include the following:

1) The means through which the NF and the Hospice Provider will communicate with each other and document these communications to ensure that the needs of Clients are addressed and met 24 hours a day;

2) An agreement on the Client's Hospice Service plan of care by the NF staff;

3) A means through which changes in Client status are reported to the Hospice Provider and NF;

4) A provision stating that the Hospice Provider is considered the primary provider and is responsible for any Medically Necessary routine care or continuous care related to the Terminal Illness and related conditions;

5) A provision stating that the Hospice Provider assumes responsibility for determining the appropriate course of Hospice Services, including the determination to change the level of services provided;

6) An agreement that it is the NF provider's responsibility to continue to furnish 24 hour Room and Board care, meeting the personal care, durable medical equipment and nursing needs that would have been provided by the NF at the same level of care provided prior to Hospice Services being Elected;

7) An agreement that it is the Hospice Provider's responsibility to provide services at the same level and to the same extent that those services would be provided if the Client were residing in his or her own residence;

8) A provision that the Hospice Provider may use NF personnel, where permitted by State law and as specified by the agreement, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice Provider would routinely use the services of a Client's family in implementing the plan of care;

9) The NF remains responsible for compliance with mandatory reporting of such violations to the State's protective services agency. As such, the Hospice Provider and its staff or subcontractors must report all alleged violations of a Client's person involving mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of Client property to the NF administrator within 24 hours of the Hospice Provider becoming aware of the alleged violation;

10) Bereavement services that the Hospice Provider will provide to the NF staff;

11) The amount to be paid to the NF or ICF/IID by the Hospice Provider; and

12) An agreement describing whether the Hospice Provider or the NF will be responsible for collecting the Client's patient payment for his or her care.

2. Intermediate Care Facilities for Individuals with Intellectual Disabilities, Independent Residential Support Services, and Group Residential Support Services settings:

a. Hospice Services may be provided to a Client who resides in a Medicaid participating ICF/IID, IRSS or GRSS residential settings. When a Client resides in one of the settings, the Client remains a resident of the ICF/IID, IRSS or GRSS residence. The Hospice Provider must provide services as if treating a Client in his or her place of residence.

b. The Hospice Provider is not responsible for reimbursing the IRSS or GRSS for the Client's Room and Board.

c. In order for a Client to receive Hospice Services while residing in these settings, the Hospice Provider must work with the ICF/IID, IRSS or GRSS to:

i) Notify the ICF/IID, IRSS or GRSS that the Client has Elected Hospice and the expected date that Hospice Services will commence;

ii) Ensure the ICF/IID, IRSS or GRSS concurs with the Hospice plan of care;

iii) Determine the responsibilities covered under the ICF/IID, IRSS or GRSS so that the Hospice Provider does not duplicate service (to include medication and supplies), including:

1) An agreement that the Hospice Provider will be responsible to provide services at the same level and to the same extent as those services would be provided if the Client were residing in his or her private residence; and

2) An agreement of the services the ICF/IID, IRSS or GRSS personnel will perform, where permitted by State law, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice Provider would routinely use the services of a Client's family in implementing the plan of care;

iv) Develop a coordinated plan of care to ensure that the Client's needs are met;

v) Develop a communication plan through which the Hospice Provider and the ICF/IID, IRSS or GRSS will communicate changes in the Client's condition or changes in the Client's care plan to ensure that the Client's needs are met; and

vi) Ensure bereavement services are available to the staff and caregivers of the Client.

3. In settings other than nursing facilities and ICF/IIDs, the Hospice Provider and assisted living residence or foster home must develop an agreement related to the provision of care to the Client, including;

   a. Hospice Provider staff access to and communication with staff or caregivers in these facilities or homes;

   b. Developing an integrated plan of care;

   c. Documenting both respective entities' records, or other means to ensure continuity of communication and easy access to ongoing information;

   d. Role of any Hospice vendor in delivering and administering any supplies and medications;

   e. Ordering, renewing, delivering and administering medications;

   f. Role of the attending physician and process for obtaining and implementing orders;

   g. Communicating Client change of condition; and

   h. Changes in the Client's needs that necessitate a change in setting or level of care.

**8.550.6 ELIGIBLE CLIENTS**

**8.550.6.A. Requirements**

To be eligible to Elect Hospice Services, all of the following requirements must be met:

1. Clients must be Medicaid eligible on the dates of service for which Medicaid-covered Hospice Services are billed. The services must be Medically Necessary, including certification of the Client's Terminal Illness, and appropriate to the Client's needs for Hospice Services to be covered by Medicaid.

2. The Client has been certified as being Terminally Ill by an attending physician or the Hospice Provider's medical director.

3. Before services are provided, an initial plan of care must be established by the Hospice Provider in collaboration with the Client and anyone else that the Client wishes to have present for care planning. When the Client is unable to direct his or her own care, care planning must involve the Client's family or caregiver.

4. The Client has agreed to cease any and all curative treatment. Clients ages 20 and younger are exempt from this requirement.

5. Hospice Clients residing in an ICF/IID or NF must meet the Hospice eligibility criteria pursuant to Section 8.550 et. seq., together with functional eligibility, medical eligibility criteria, and the financial eligibility criteria for institutional care as required by Sections 8.400, 8.401, and 8.482.

6. Clients who do not meet eligibility requirements for State Plan Medicaid may be eligible for Medicaid through the long-term care eligibility criteria, which may require the Client to pass a level of care assessment through a designated case management agency.

**8.550.6.B. Special Requirements**

1. Eligibility for, and access to, Hospice Services does not fall within the purview of the long-term care Single Entry Point system for prior authorization.

2. Nursing facility placement for a Client who has Medicaid and has Elected Hospice Services in a nursing facility does not require a ULTC 100.2 assessment. The nursing facility must complete a Pre Admission Screening and Resident Review (PASRR).

**8.550.7 DISCHARGE**

**8.550.7.A. A Hospice Provider may discharge a client when:**

1. The client moves out of the Hospice Provider's service area or transfers to another Hospice Provider;

2. The Hospice Provider determines that the client is no longer Terminally Ill; or

3. The Hospice Provider determines, under a policy set by the Hospice Provider for the purpose of addressing discharge for cause that meets the requirements of 42 C.F.R. Section 418.26(a)(3) (2018), that the client's (or other person in the client's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care or the Hospice Provider's ability to operate effectively is seriously impaired. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

    a. The Hospice Provider must:

        i) Advise the client that a discharge for cause is being considered;

        ii) Make a serious effort to resolve the problem presented by the situation;

        iii) Ascertain that the proposed discharge is not due to the client's use of necessary Hospice Services;

        iv) Document the problem and the effort made to resolve the problem; and

        v) Enter this documentation into the client's medical record.

4. The Hospice Provider must obtain a written discharge order from the Hospice Provider's medical director prior to discharging a client for any of the reasons in this section.

5. The Hospice Provider medical director must document that the attending physician involved in the client's care has been consulted about the discharge and include the attending physician's review and decision in the discharge note.

6. The Hospice Provider must have in place a discharge planning process that takes into account the prospect that a client's condition might stabilize or otherwise change such that the client cannot continue to be certified as Terminally Ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the client is discharged because he or she is no longer Terminally Ill.

7. The Hospice Provider must implement the discharge planning process to ensure to the maximum extent feasible, that the client's needs for health care and related services upon termination of Hospice Services will be met.

8. The Hospice Provider must document whether the client or client's authorized representative was involved in the discharge planning.

9. The Hospice Provider must document the transition plan for the client.

**8.550.8 PROVIDER REQUIREMENTS**

**8.550.8.A. Licensure**

The Hospice Provider must be licensed by the Colorado Department of Public Health and Environment, have a valid provider agreement with the Department and be Medicare certified as being in compliance with the conditions of participation for a Hospice Provider as set forth at 42 C.F.R. §§ 418.52 through 418.116 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

**8.550.8.B. Qualified Personnel**

Hospice Services must be performed by appropriately qualified personnel:

1. Physicians who are a doctor of medicine or osteopathy licensed in accordance with the Colorado Medical Practice Act (C.R.S. § 12-36-101, et seq.);

2. Advanced Practice Nurses and Physician Assistants licensed in accordance with the Colorado Nurse Practice Act and the Colorado Medical Practice Act;

3. Registered Nurses (RN) and Licensed Practical Nurses (LPN), licensed in accordance with the Colorado Nurse Practice Act (C.R.S. § 12-38-101,et seq.);

4. Physical therapists who are licensed in accordance with the Colorado Physical Therapy Practice Act (C.R.S. § 12-41-101et seq.);

5. Occupational therapists who are licensed in accordance with the Colorado Occupational Therapy Practice Act (C.R.S. § 12-40.5-101, et seq.);

6. Speech language pathologists who are certified by the American Speech-Language-Hearing Association (ASHA);

7. Licensed clinical social workers who have a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education, or a baccalaureate degree in psychology, sociology, or other field related to social work and who are supervised by a social worker with a Master's Degree in Social Work and who have one year of social work experience in a health care setting;

8. Certified nurse aides who are certified in accordance with the Colorado Nurse Aide Practice Act (C.R.S. § 12-38-101, et seq.) and who have appropriate training. At the option of the Hospice Provider, homemakers with appropriate training may provide homemaking services, which is included as a component of Hospice Services;

9. Hospice volunteers who have received volunteer orientation and training that is consistent with Hospice industry standards;

10. Members of the clergy or religious support services; and

11. Members of the Hospice Interdisciplinary Team acting within the scope of his or her license, as determined by the Hospice Provider.

**8.550.8.C. Laboratory Services**

1. Laboratory services provided by Hospice Providers are subject to the requirements of 42 U.S.C. § 263a (2012) entitled the Clinical Laboratory Improvement Act of 1967 (CLIA). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

2. Hospice Providers must obtain a CLIA waiver from the Department of Public Health and Environment to perform laboratory tests. A Hospice Provider that collects specimens, including drawing blood, but does not perform testing of specimens is not subject to CLIA requirements.

**8.550.8.D. Provider Responsibilities**

1. A Hospice Provider must routinely provide all core services by staff employed by the Hospice Provider. These services must be provided in a manner consistent with acceptable standards of practice. Core services include nursing services, certified nursing aide services, medical social services, and counseling.

2. The Hospice Provider may contract for physician services. The contracted provider(s) will function under the direction of the Hospice Provider's medical director.

3. A Hospice Provider may use contracted staff, if necessary, to supplement Hospice Provider employees in order to meet the needs of the Client. A Hospice Provider may also enter into a written arrangement with another Colorado Medicaid and Medicare certified Hospice program for the provision of core services to supplement Hospice Provider employees/staff to meet the needs of Clients. Circumstances under which a Hospice Provider may enter into a written arrangement for the provision of core services include:

    a. Unanticipated periods of high Client loads, staffing shortages due to illness or other short-term, temporary situations that interrupt Client care;

    b. Temporary travel of a Client outside of the Hospice Provider's service area; and

    c. When a Client resides in a NF, ICF/IID, IRSS or GRSS.

4. The Hospice Provider must ensure, prior to the provision of Medicaid Hospice Services, that Clients are evaluated to determine whether or not they are Medicare eligible. Hospice Services are not covered by Medicaid during the period when a Client is Medicare eligible, except for Clients residing in a NF in which case Medicaid pays to the Hospice Provider an amount for Room and Board.

5. The Hospice Provider must ensure a Client, or his or her legally authorized representative, completes the Hospice Election form prior to or at the time Medicaid Hospice Services are provided.

6. Medicare Hospice Election may not occur retroactively. Therefore, Clients with retroactive Medicare eligibility may receive Medicaid covered services during the retroactive coverage period. The Hospice Provider must make reasonable efforts to determine a Client's status concerning Medicare eligibility or a Client's application for Medicare and must maintain documentation of these efforts. These efforts must include routine and regular inquiry to determine Medicare eligibility for Clients who reach the age of sixty-five and regular inquiry for Clients who indicate they receive Social Security Disability Income (SSDI) and are approaching the 24th month of receipt of SSDI. See also Section 8.550.3.

7. Clients who are eligible for Medicare and Medicaid must Elect Hospice Services under both programs.

8. If a Client becomes eligible for Medicaid while receiving Medicare Hospice benefits, Medicare Hospice coverage continues under its current Election period and Medicaid Hospice coverage begins at Medicaid's first Election period.

9. An individual Client Record must be maintained by the designated Hospice Provider and must include:

    a. Documentation of the Client's eligibility for and Election of Hospice Services including the physician certification and recertification of Terminal Illness;

    b. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes;

    c. The amount, frequency, and duration of services delivered to the Client based on the Client's plan of care;

    d. Documentation to support the care level for which the Hospice Provider has claimed reimbursement; and

    e. Medicaid provider orders.

10. Incomplete documentation in the Client Record shall be a basis for recovery of overpayment.

11. Notice of the Client's Election and Benefit Periods must be provided to the Medicaid fiscal agent in such form and manner as prescribed by the Department.

12. The Hospice Provider must provide reports and keep records as the Department determines necessary including records that document the cost of providing care.

13. The Hospice Provider must perform case management for the Client. Medicaid will not reimburse the Hospice Provider separately for this responsibility.

14. The Hospice Provider must designate an Interdisciplinary Team composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the Clients and his or her family facing Terminal Illness and bereavement. Interdisciplinary Team members must provide the care and services offered by the Hospice Provider. The Interdisciplinary Team, in its entirety, must supervise the care and services.

15. The Interdisciplinary Team includes, but is not limited to:

    a. A Doctor of Medicine or Osteopathy, advanced practice nurse, or physician assistant (who is an employee or under contract with the Hospice Provider);

    b. A registered nurse or licensed practical nurse;

    c. A social worker;

    d. A pastoral or other counselor; and

    e. The volunteer coordinator or designee.

16. The Hospice Provider must designate a member of the Interdisciplinary Team to provide coordination of care and to ensure continuous assessment of each Client's and family's needs and implementation of the interdisciplinary plan of care. The designated member must oversee coordination of care with other medical providers and agencies providing care to the Client.

17. All Hospice Services and services furnished to Clients and their families must follow an individualized written plan of care established by the Hospice Interdisciplinary Team in collaboration with the Client's primary provider (if any), the Client or his or her representative, and the primary caregiver in accordance with the Client's needs and desires.

18. The plan of care must be established prior to providing Hospice Services and must be based on a medical evaluation and the written assessment of the Client's needs and the needs of the Client's primary caregiver(s).

19. The plan of care must be maintained in the Client's record and must specify:

    a. The Client's medical diagnosis and prognosis;

    b. The medical and health related needs of the Client;

    c. The specific services to be provided to the Client through Hospice and when necessary the NF, ICF/IID, IRSS or GRSS;

    d. The amount, frequency and duration of these services; and

    e. The plan of care review date.

20. The plan of care must be reviewed as needed, but no less frequently than every 15 days. The Interdisciplinary Team leader must document each review. The Interdisciplinary Team members, including the Medicaid provider who is managing the Client's care, must sign the plan of care.

21. The Hospice Provider must ensure that each Client and his or her primary care giver(s) receive education and training provided by the Hospice Provider as appropriate based on the Client's and primary care giver(s)' responsibilities for the care and services identified in the plan of care.

22. The Hospice Provider is responsible for paying for medications, durable medical equipment, and medical supplies needed for the palliation and management of the Client's Terminal Illness.

**8.550.9 REIMBURSEMENT**

**8.550.9.A. Reimbursement Determination**

Reimbursement follows the method prescribed in 42 C.F.R. §§ 418.301 through 418.309 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

1. Reimbursement rates are determined by the following:

    a. Rates are published by the Department annually in compliance with the Centers for Medicare and Medicaid Services (CMS) state Medicaid Hospice reimbursement.

    b. Each care-level per-diem rate is subject to a wage index multiplier, to compensate for regional differences in wage costs, plus a fixed non-wage component.

    c. The Hospice wage indices are published annually by October 1 in the Federal Register.

    d. Rates are adjusted for cost-of-living increases and other factors as published by the Centers for Medicare and Medicaid Services.

    e. Continuous home care is reimbursed at the applicable hourly rate, the per-diem rate divided by 24 hours, multiplied by the number of hourly units billed from eight up to 24 hours per day of continuous care (from midnight to midnight).

    f. Reimbursement for routine home care and continuous home care must be based upon the geographic location at which the service is furnished and not on the business address of the Hospice Provider.

2. Reimbursement for Hospice Services must be made at one of four predetermined care level rates, including the routine home care rate, continuous home care rate, inpatient respite care rate, and general inpatient care rate. If no other level of care is indicated on a given day, it is presumed that routine home care is the applicable rate.

    a. Care levels and reimbursement guidelines:

        i) The routine home care rate is reimbursed for each day the Client is at home and not receiving continuous home care. This rate is paid without regard to the volume or intensity of Home Care Services provided. This is the service type that must be utilized when a Client resides in a NF, ICF/IID, IRSS or GRSS unless the Client is in a period of crisis.

ii) The continuous home care rate is reimbursed when continuous home care is provided and only during a period of medical crisis to maintain a Client at home. A period of crisis is a period in which a Client requires continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Either a registered nurse or a licensed practical nurse must provide more than half of the billed continuous homecare hours. Homemaker and certified nurse aide services may also be provided to supplement nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate shall be reimbursed up to 24 hours a day. Continuous home care must not be utilized when a Client resides in a NF, ICF/IID, IRSS or GRSS unless the Client is in a period of crisis.

iii) The inpatient respite care rate is paid for each day on which the Client is in an approved inpatient facility for respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. Payment for inpatient respite care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9.B.

iv) The general inpatient rate must be paid only during a period of medical crisis in which a Client requires 24-hour continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Payment for general inpatient care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9.B.

3. The Hospice Provider is paid a Room and Board fee in addition to the Hospice per diem for each routine home care day and continuous care day provided to Clients residing in an ICF/IID or NF.

a. The payment for Room and Board is billed by and reimbursed to the Hospice provider on behalf of the Client residing in the facility. The Department reimburses 95 percent of the facility per diem amount less any patient payments.

b. Payments for Room and Board are exempt from the computation of the Hospice payment cap.

c. The Hospice Provider must forward the Room and Board payment to the NF or ICF/IID.

d. Clients who are eligible for Post Eligibility Treatment of Income (PETI) shall be eligible for PETI payments while receiving services from a Hospice Provider. The Hospice Provider must submit claims on behalf of the Client and nursing facility or ICF/IID.

e. Patient payments for Room and Board charges must be collected for Hospice Clients residing in a NF or ICF/IID as required by Section 8.482. While the Medicaid NF and ICF/IID Room and Board payments must be made directly to the Hospice Provider, the patient payment must be collected by the nursing facility or ICF/IID.

f. Nursing facilities, ICF/IIDs, and Hospice Providers are responsible for coordinating care of the Hospice Client and payment amounts.

4. The Hospice Provider is reimbursed for routine home care or continuous home care provided to Clients residing in a NF or ICF/IID. If a Client is eligible for Medicare and Medicaid and the Client resides in a NF or ICF/IID, Medicare reimburses the Hospice Services, and Medicaid reimburses for Room and Board.

5. Reimbursement for date of discharge:

a. Reimbursement for date of discharge must be made at the appropriate home care rate for the day of discharge from general or respite inpatient care, unless the Client dies at an inpatient level of care. When the Client dies at an inpatient level of care, the applicable general or respite inpatient rate is paid for the discharge date.

b. Reimbursement for nursing facility and ICF/IID residents is made for services delivered up to the date of discharge when the Client is discharged, alive or deceased, including applicable per diem payment for the date of discharge.

**8.550.9.B. Reimbursement Limitations**

1. Aggregate payment to the Hospice Provider is subject to an annual indexed aggregate cost cap. The method for determining and reporting the cost cap must be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Sections 418.308 and 418.309 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

2. Aggregate days of care provided by the Hospice Provider are subject to an annual limitation of no more than 20 percent general and respite inpatient care days. The method for determining and reporting the inpatient days percentage shall be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Section 418.302 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Inpatient days in excess of the 20 percent limitation must be reimbursed at the routine home care rate.

3. The Hospice Provider must not collect co-payments, deductibles, cost sharing or similar charges from the client for Hospice Services including biological and respite care.

4. The Hospice Provider must submit all billing to the Medicaid fiscal agent within such timeframes and in such form as prescribed by the Department.

5. Specific billing instructions for submission and processing of claims is provided in the Department's Hospice billing manual.

**8.550.9.C. State-Only Hospice Room and Board Reimbursement**

1. As used in this section, unless context otherwise requires:

a. "Eligible Patient" means a person who is enrolled in Colorado Medicaid at the time the service is provided and who:

i) Is eligible under Colorado Medicaid for care in a nursing facility at the time the service is provided;

ii) Has a hospice diagnosis; and

iii) Despite attempts to secure a bed, is unable to secure a Medicaid bed in a nursing facility due to COVID-19 impacts, complexity of medical care, behavioral health issues, or other issues as determined by the Department.

b. "Qualified Hospice Provider" means a hospice provider that:

i) Has been continuously enrolled with the Department since at least January 1, 2021;

ii) Provided hospice services to the eligible patient in a licensed hospice facility during the period beginning in the last quarter of the 2020-2021 state fiscal year through the 2021-2022 state fiscal year; and

iii) Complies with any billing or administrative requests of the Department for purposes of determining eligibility for and administering the state payment.

2. Qualified Hospice Providers who provide hospice care in a licensed hospice facility to an Eligible Patient may receive a room and board payment equal to one-half (1/2) of the statewide average per diem rate, as defined in C.R.S. § 25.5-6-201. The payment is subject to the following limitations:

a. Payment is limited to not more than twenty-eight (28) days per Eligible Patient.

b. No payments will be made after June 30, 2022 or after appropriations are exhausted, whichever occurs first, in accordance with C.R.S. § 25.5-4-424.

**8.551 [Repealed eff. 02/01/2014]**

## 8.552 IN-HOME SUPPORT SERVICES

### 8.552.1 DEFINITIONS

A. Assessment means a comprehensive evaluation with the client seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department prescribed tool to complete assessments.

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

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

D. Care Plan means a written plan of care developed between the client or the client's Authorized Representative, IHSS Agency and Case Management Agency that is authorized by the Case Manager.

E. Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6- 106, C.R.S., and has a current provider participation agreement with the Department.

F. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.

G. 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 client and avoid institutionalization.

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

I. Health Maintenance Activities means those routine and repetitive skilled health-related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if they were physically able, or that would be carried out by Family Members or friends if they were available. These activities include skilled tasks typically performed by a Certified Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment and judgement of a licensed nurse.

J. Homemaker Services means general household activities provided by an Attendant in the client's primary living space to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

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

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

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

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

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

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

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

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

**8.552.2 ELIGIBILITY**

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

1. Be enrolled in a Medicaid program approved to offer IHSS.

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

3. Clients who elect or are required to have an Authorized Representative must appoint an Authorized Representative who has the judgment and ability to assist the client in acquiring and using services,

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

8.552.2.B. IHSS eligibility for a client will end if:

1. The client is no longer enrolled in a Medicaid program approved to offer IHSS.

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

3. The client refuses to designate an Authorized Representative or receive assistance from an IHSS Agency when the client is unable to direct their own care as documented by the client's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.

4. The client provides false information or false records.

5. The client no longer demonstrates a current need for Attendant support services.

**8.552.3 COVERED SERVICES**

8.552.3.A. Services are for the benefit of the client. Services for the benefit of other persons are not reimbursable.

8.552.3.B. Services available for eligible adults:

1. Homemaker

2. Personal Care

3. Health Maintenance Activities.

8.552.3.C. Services available for eligible children:

1. Health Maintenance Activities.

8.552.3.D. Service Inclusions:

1. Homemaker:

   a. Routine housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas;

   b. Meal preparation;

   c. Dishwashing;

   d. Bed making;

   e. Laundry;

   f. Shopping for necessary items to meet basic household needs.

2. 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 client'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 client to and from the bathroom;

ii) Assistance with bed pans, urinals, and commodes;

iii) Changing incontinence clothing or pads;

iv) Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v) Emptying ostomy bags;

vi) Perineal care.

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;

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 client is able to assist or direct.

g. Transferring a client when the client 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 client and Attendant are fully trained in the use of the equipment and the client can direct and assist with the transfer.

h. Mobility assistance when the client has the ability to reliably balance and bear weight or when the client is independent with an assistive device.

i. Positioning when the client is able to verbally or non-verbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.

j. Medication Reminders when medications have been preselected by the client, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:

i) Medication minders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;

ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable to do so independently.

k. Cleaning and basic maintenance of durable medical equipment.

l. Protective oversight when the client requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property.

m. Accompanying includes going with the client, as indicated on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the client may include providing one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the attendant.

3. Health Maintenance Activities:

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

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

i) Client is unable to complete task independently;

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

iii) Client 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 client is unable to participate in the task;

iv) Oral suctioning is required;

v) There is decreased oral sensitivity or hypersensitivity;

vi) Client 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 client has a medical condition involving peripheral circulatory problems;

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

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

iv. The client 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. The client is unable to assist or direct care;

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

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

g. Feeding is considered a health maintenance task when the client 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 client is on a prescribed modified texture diet;

iii) The client has a physiological or neurogenic chewing or swallowing problem;

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

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

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

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

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

ii) The client 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 client 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 client 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 of mouth and nose

v) Nebulizers

vi) Ventilator and tracheostomy care

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

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

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

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

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 client is unable to assist or direct care;

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

iii) the client has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional.

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

i) the client is unable to assist or direct care, or

ii) the client is unable to complete task independently.

**8.552.4 CLIENT AND AUTHORIZED REPRESENTATIVE PARTICIPATION AND SELF-DIRECTION**

8.552.4.A. A client or their Authorized Representative may self-direct the following aspects of service delivery:

1. Present a person(s) of their own choosing to the IHSS Agency as a potential Attendant. The client must have adequate Attendants to assure compliance with all tasks in the Care Plan.

2. Train Attendant(s) to meet their needs.

3. Dismiss Attendants who are not meeting their needs.

4. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.

5. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the client's Licensed Medical Professional.

6. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.

7. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.

8. Request a reassessment, as described at Section 8.393.2.D, if level of care or service needs have changed.

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

8.552.4.C. If the client is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:

1. Must be at least 18 years of age.

3. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.

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

8.552.4.E. IHSS clients who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS client.

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

**8.552.5 IHSS AGENCY ELIGIBILITY**

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

8.552.5.B. The provider agreement for an IHSS Agency may be terminated, denied, or non-renewed pursuant to Section 8.076.5.

8.552.5.C. Administrators or managers as defined at 6 CCR 1011-1 Chapter 26 shall satisfactorily complete the Department authorized training on IHSS rules and regulations prior to Medicaid certification and annually thereafter.

**8.552.6 IHSS AGENCY RESPONSIBILITIES**

8.552.6.A. The IHSS Agency shall assure and document that all clients are provided the following:

1. Independent Living Core Services

   a. An IHSS Agency must provide a list of the full scope of Independent Living Core Services provided by the agency to each client on an annual basis. The IHSS Agency must keep a record of each client's choice to utilize or refuse these services, and document services provided

2. Attendant training, oversight and supervision by a licensed health care professional.

3. The IHSS agency shall provide 24-hour back-up service for scheduled visits to clients 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.

8.552.6.B. The IHSS Agency shall adhere to the following:

1. If the IHSS Agency admits clients 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 client are met.

2. The IHSS Agency shall only accept clients for care or services based on a reasonable assurance that the needs of the client can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.

    a. There shall be documentation in the Care Plan or client record of the agreed upon days and times of services to be provided based upon the client's needs that is updated at least annually.

3. If an IHSS Agency receives a referral of a client who requires care or services that are not available at the time of referral, the IHSS Agency shall advise the client or their Authorized Representative and the Case Manager of that fact.

    a. The IHSS Agency shall only admit the client if the client or their Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.

4. The IHSS Agency shall ensure orientation is provided to clients 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 client rights and responsibilities.

5. The IHSS Agency will keep written service notes documenting the services provided at each visit.

8.552.6.C. The IHSS Agency is the legal employer of a client'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.

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

8.552.6.E. The IHSS Agency will complete an intake assessment following referral from the Case Manager. The IHSS Agency will develop a Care Plan in coordination with the Case Manager and client. Any proposed services outlined in the Care Plan that may result in an increase in authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to start of services.

8.552.6.F. The IHSS Agency shall ensure that a current Care Plan is in the client's record, and that Care Plans are updated with the client at least annually or more frequently in the event of a client's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.

1. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope and duration of each service to be provided to the client for each day and visit. The Care Plan shall be signed by the client or the client's Authorized Representative and the IHSS Agency.

    a. Secondary or contiguous tasks must be outlined on the care plan as described in Section 8.552.8.F.

2. In the event of the observation of new symptoms or worsening condition that may impair the client's ability to direct their care, the IHSS Agency, in consultation with the client or their Authorized Representative and Case Manager, shall contact the client's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the client's revised Care Plan, with the client and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval.

8.552.6.G. The IHSS Agency's Licensed Health Care Professional is responsible for the following activities:

1. Administer a skills validation test for Attendants who will perform Health Maintenance Activities. Skills validation for all assigned tasks must be completed prior to service delivery unless postponed by the client or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS in the client's file. In no event shall the skills validation be postponed for more than thirty (30) days after services begin to prevent interruption in services.

2. Verify and document Attendant skills and competency to perform IHSS and basic client safety procedures.

3. Counsel Attendants and staff on difficult cases and potentially dangerous situations.

4. Consult with the client, Authorized Representative or Attendant in the event a medical issue arises.

5. Investigate complaints and critical incidents within ten (10) calendar days as defined in Section 8.487.15.

6. Verify the Attendant follows all tasks set forth in the Care Plan.

7. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the client, their Authorized Representative, or the Case Manager.

8. Provide in-home supervision for the client as recommended by their Licensed Medical Professional and as agreed upon by the client or their Authorized Representative.

8.552.6.H. At the time of enrollment and following any change of condition, the IHSS Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the client record.

1. The IHSS Agency shall collaborate with the client or client's Authorized Representative to determine the level of supervision provided by the IHSS Agency's Licensed Health Care Professional beyond the requirements set forth at Section 25.5-6-1203, C.R.S.

2. The client may decline recommendations by the Licensed Medical Professional for in-home supervision. The IHSS Agency must document this choice in the client record and notify the Case Manager. The IHSS Agency and their Licensed Health Care Professional, Case Manager, and client or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

8.552.6.I. The IHSS Agency shall assure and document that all Attendants have received training in the delivery of IHSS prior to the start of services. Attendant training shall include:

1. Development of interpersonal skills focused on addressing the needs of persons with disabilities.

2. Overview of IHSS as a service-delivery option of consumer direction.

3. Instruction on basic first aid administration.

4. Instruction on safety and emergency procedures.

5. Instruction on infection control techniques, including universal precautions.

6. Mandatory reporting and critical incident reporting procedures.

7. Skills validation test for unskilled tasks assigned on the care plan.

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

8.552.6.K. With the support of the IHSS Agency, Attendants must adhere to the following:

1. Must be at least 16 years of age and demonstrate competency in caring for the client to the satisfaction of the client or Authorized Representative.

   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).

2. May be a Family Member subject to the reimbursement and service limitations in Section 8.552.8.

3. Must be able to perform the assigned tasks on the Care Plan.

4. Shall not, in exercising their duties as an IHSS Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse as defined in Section 25.5-6-1203, C.R.S.

5. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.

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

**8.552.7 CASE MANAGEMENT AGENCY RESPONSIBILITIES**

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

8.552.7.B. The Case Manager will initiate a referral to the IHSS Agency of the client 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.

8.552.7.C. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:

1. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.

2. The Shared Responsibilities Form shall be completed upon enrollment and following any change of condition. If the client requires an Authorized Representative, the Shared Responsibilities Form must include the designation and attestation of an Authorized Representative.

8.552.7.D. Upon the receipt of the Care Plan, the Case Manager shall:

1. Review the Care Plan within five business days of receipt to ensure there is no disruption or delay in the start of services.

2. Ensure all required information is in the client's Care Plan and that services are appropriate given the client's medical or functional condition. If needed, request additional information from the client, their Authorized Representative, the IHSS Agency, or Licensed Medical Professional regarding services requested.

3. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.

4. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the client's eligible benefits.

5. Collaborate with the client or their Authorized Representative and the IHSS Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.

6. Authorize cost-effective and non-duplicative services via the PAR. Provide a copy of the PAR to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.

7. Work collaboratively with the IHSS Agency, client, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.

a. Case Manager will complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the client's rights to fair hearing, and appeal procedures.

8.552.7.E. The Case Manager shall ensure cost-effectiveness and non-duplication of services by:

1. Documenting the discontinuation of previously authorized agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by IHSS.

2. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.

   a. A client may receive non-duplicative services from multiple Attendants or agencies if appropriate for the client's level of care and documented service needs.

3. Ensuring the client's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan, and requesting additional information as needed.

4. Coordinating transitions from a hospital, nursing facility, or other agency to IHSS. Assisting client with transitions from IHSS to alternate services if appropriate.

5. Collaborating with the client 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 client's condition and functioning.

6. Completing a reassessment if requested by the client as described at Section 8.393.2.D., if level of care or service needs have changed.

8.552.7.F. The Case Manager shall not authorize more than one consumer-directed program on the client's PAR.

8.552.7.G. The Case Manager shall participate in training and consultative opportunities with The Department's Consumer-Directed Training & Operations contractor.

8.552.7.H. Additional requirements for Case Managers:

1. Contact the client or Authorized Representative once a month during the first three months of receiving IHSS to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.

2. Contact the client 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.

3. Contact the client or Authorized Representative when a change in Authorized Representative occurs and continue contact once a month for three months after the change takes place.

4. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the agency, and supervision provided. The Case Manager must document and keep record of the following:

    a. IHSS Care Plans;

    b. In-home supervision needs as recommended by the Physician;

    c. Independent Living Core Services offered and provided by the IHSS Agency; and

    d. Additional supports provided to the client by the IHSS Agency.

8.552.7.I. Start of Services

1. Services may begin only after the requirements defined at Sections 8.552.2, 8.552.6.E., 8.552.6.I., and 8.552.7.C. have been met.

2. Department review for cost-containment as defined at Sections 8.486.80 and 8.506.12 must be completed prior to issuance of the PAR to the IHSS Agency.

3. The Case Manager shall establish a service period and submit a PAR, providing a copy to the IHSS Agency prior to the start of services.

## 8.552.8 REIMBURSEMENT AND SERVICE LIMITATIONS

8.552.8.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 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.

8.552.8.B. IHSS Personal Care services must comply with the rules for reimbursement set forth at Section 8.489.50. IHSS Homemaker services must comply with the rules for reimbursement set forth at Section 8.490.5.

8.552.8.C. Family Members are authorized to provide only Personal Care services or Health Maintenance Activities for eligible adults and Health Maintenance Activities for eligible children.

8.552.8.D. Services rendered by an Attendant who shares living space with the client or Family Members are reimbursable only when there is a determination by the Case Manager, made prior to the services being rendered, that the services meet the definition of Extraordinary Care.

8.552.8.E. Family Members shall not be reimbursed for more than forty (40) hours of Personal Care services in a seven (7) day period.

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

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

b. Contiguous means before, during or after the main task(s). Contiguous tasks must be completed before, during, or after the Health Maintenance Activity. There must be documented evidence that the contiguous task is necessary for the health and safety of the client. Contiguous tasks do not add units to the care plan.

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

8.552.8.G. Restrictions on allowable Personal Care units shall not apply to parents who provide Attendant services to their eligible adult children under In-Home Support Services as set forth at Section 8.485.204.D.

8.552.8.H. The IHSS Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved PAR. The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.

8.522.8.I. The IHSS Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.

8.552.8.J. Services by an Authorized Representative to represent the client are not reimbursable. IHSS services performed by an Authorized Representative for the client that they represent are not reimbursable.

8.552.8.K. An IHSS Agency shall not be reimbursed for more than twenty-four hours of IHSS service in one day by an Attendant for one or more clients collectively.

8.552.8.L. A client cannot receive IHSS and Consumer Directed Attendant Support Services (CDASS) at the same time.

8.552.8.M. Independent Living Core Services, attendant training, and oversight or supervision provided by the IHSS Agency's Licensed Health Care Professional are not separately reimbursable. No additional compensation is allowable for IHSS Agencies for providing these services.

8.552.8.N. Travel time shall not be reimbursed.

8.552.8.O. Companionship is not a benefit of IHSS and shall not be reimbursed.

**8.552.9 DISCONTINUATION AND TERMINATION OF IN-HOME SUPPORT SERVICES**

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

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

8.552.9.C. The Case Manager may terminate a client's participation in IHSS for the following reasons:

1. The client or their Authorized Representative fails to comply with IHSS program requirements as defined in Section 8.552.4, or

2. A client no longer meets program criteria, or

3 The client provides false information, false records, or is convicted of fraud, or

4. The client or their Authorized Representative exhibits Inappropriate Behavior and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.

a. The IHSS Agency and Case Manager are required to assist the client 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

8.552.9.D. When an IHSS Agency discontinues services, the agency shall give the client and the client'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 client 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.

1. Exceptions will be made to the requirement for advanced notice when the IHSS Agency has documented that there is an immediate threat to the client, IHSS Agency, or Attendants.

2. Upon IHSS Agency discretion, the agency may allow the client or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

8.552.9.E. If continued services are needed with another agency, the current IHSS Agency shall collaborate with the Case Manager and client 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 client’s safety and welfare.

8.552.9.F. In the event of discontinuation or termination from IHSS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for termination, information about the client’s rights to fair hearing, and appeal procedures. Once notice has been given, the client or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.

## 8.553 LIFE SKILLS TRAINING, HOME DELIVERED MEALS, PEER MENTORSHIP, TRANSITION SETUP SERVICES, & HOME DELIVERED MEALS POST-HOSPITAL DISCHARGE

### 8.553.1 GENERAL DEFINITIONS

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

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

C. Community risk level means the potential for a member living in a community-based arrangement to require emergency services, to be admitted to a hospital or nursing facility, evicted from their home or involved with law enforcement due to identified risk factors.

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

E. Discharge means a release from the hospital following a minimum 24-hour stay following admission.

F. Home and Community Based Services (HCBS) Waivers means services and supports provided through a waiver authorized in Section 1915(c) of the Social Security Act, 42 U.S.C. Section 1396n(c) and provided in community settings to a member who requires an institutional level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

G. 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.

H. Institutional Setting means an institution or institution-like setting, including a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Regional Center or Home and Community Based setting that is operated by the state.

I. Life Skills Training (LST) means individualized training designed and directed with the member to develop and maintain his/her ability to independently sustain himself/herself physically, emotionally, socially and economically in the community. LST may be provided in the member's residence, in the community, or in a group living situation.

J. Life Skills Training program service plan is a plan that describes the type of services that will be provided as part of the LST, and the scope, frequency, and duration of services necessary to meet the client's needs, enabling the member to independently sustain himself/herself physically, emotionally, socially, and economically in the community. This plan must be developed with input from the member and the provider.

K. Member has the same meaning and use as the terms "Member" and/or "Client" in used Section 8.500.1, 8.500.90, .

L. Nutritional Meal Plan is a plan consisting of the complete nutritional regimen that the Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) recommends to the member for overall health and wellness and shall include additional recommendations outside of the Medicaid-authorized meals for additional nutritional support and education.

M. 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.

N. Service Plan means the written document that identifies approved services, including Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a member to remain safely in the community and developed in accordance with the Department rules.

O. Transition Setup Authorization Request Form is a document used to request authorization for delivery of items and/or services required for the transition set up to occur. This document must be submitted to and approved by the Case Management Agency in order for the provider to receive payment.

P. Transition Setup 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.

**8.553.2 SERVICE ACCESS AND AUTHORIZATION**

A. To establish eligibility for Life Skills Training, Home Delivered Meals, or Peer Mentorship, the member must satisfy two sets of criteria: general criteria for accessing any of the three services, and criteria unique to each particular service. The member's Case Manager must not authorize Life Skills Training, Home Delivered Meals, or Peer Mentorship to continue for more than 365 days. The Department, in its sole discretion, may grant an exception based on extraordinary circumstances:

1. To be eligible for Life Skills Training, Home Delivered Meals, or Peer Mentorship, the member must satisfy the following general criteria:

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

2. To be eligible for Life Skills Training (LST), Home Delivered Meals, and Peer Mentorship, the member must participate in an assessment and satisfy the criteria unique to each particular service the member wishes to access.

a. To obtain approval for LST the member must be enrolled in the HCBS-CMHS Waiver under Section 8.509, the HCBS-EBD Waiver under Section 8.485, the HCBS-CIH Waiver under Section 8.517, or the HCBS-SLS Waiver under Section 8.500.9. The member must also demonstrate the following needs, which must be documented in the member's Service Plan:

   i. The member demonstrates a need for 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;

   ii. The member identifies skills for which training is needed and demonstrates that without the skills, the member risks his/her health, safety, or ability to live in the community;

   iii. The member demonstrates that without training he/she could not develop the skills needed; and

   iv. The member demonstrates that with training he/she has ability to acquire these skills or services necessary within 365 days.

b. To obtain approval for Home Delivered Meals, the member must be enrolled in the HCBS-BI Waiver under Section 8.515, the HCBS-CMHS Waiver under Section 8.509; the HCBS-DD Waiver under Section 8.500, the HCBS-EBD Waiver under Section 8.485, the HCBS-CIH Waiver under Section 8.517, or the HCBS-SLS Waiver under Section 8.500.9. The member must also demonstrate a need for the service, as follows:

   i. The member demonstrates a need for nutritional counseling, meal planning, and preparation;

   ii. The member shows documented dietary restrictions or specific nutritional needs;

   iii. The member lacks or has limited access to outside assistance, services, or resources through which he/she can access meals with the type of nutrition vital to meeting his/her dietary restrictions or special nutritional needs;

   iv. The member is unable to prepare meals with the type of nutrition vital to meeting his/her dietary restrictions or special nutritional needs;

   v. The member's inability to access and prepare nutritious meals demonstrates a need-related risk to health, safety, or institutionalization; and

   vi. The assessed need is documented in the member's Service Plan as part of their acquisition process of gradually becoming capable of preparing their own meals or establishing the resources to obtain their needed meals.

c. To obtain approval for Peer Mentorship, a member must be enrolled in the HCBS-BI Waiver under Section 8.515; the HCBS-CMHS Waiver under Section 8.509; the HCBS-EBD Waiver under Section 8.485; the HCBS-CIH Waiver under Section 8.517; the HCBS-DD Waiver under Section 8.500; or the HCBS-SLS Waiver under Section 8.500.9. The member must also demonstrate:

i. A need for soft skills, insight, or guidance from a peer;

ii. That without this service he/she may experience a health, safety, or institutional risk; and

iii. There are no other services or resources available to meet the need.

**8.553.3 LIFE SKILLS TRAINING (LST)**

A. INCLUSIONS

1. 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;

p. Acquiring and utilizing assistive technology when appropriate and not duplicative of training covered under other services.

All Life Skills Training shall be documented in the Life Skills Training (LST) program service plans. Reimbursement is limited to services described in the Life Skills Training (LST) program service plans.

B. LIMITATIONS AND EXCLUSIONS

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 Health, 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 may be provided with Non-Medical Transportation (NMT) if the transportation of the member is part of the LST as indicated in the LST program service plan; if not part of the training, the provider may only bill for NMT if that provider is a certified NMT provider. .

b. LST may be delivered during the provision of services by behavioral line staff only when directly authorized by the Department.

3. LST does not include services offered under the State Plan or other resources.

4. LST does not include services offered through 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.

C. PROVIDER QUALIFICATIONS

1. The provider agency furnishing services to waiver members shall abide by all general certification standards, conditions, and processes established for the member's respective waiver: HCBS-CMHS, -EBD, or -SCI waivers in Section 8.487; HCBS-SLS waiver in Section 8.500.98.

2. In accordance with 42 C.F.R Section 441.301(c)(1)(vi), providers of LST for the individual, or those who have an interest in or are employed by the provider of LST, must not authorize services or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to authorize services and/or develop person-centered plans in a geographic area also provides HCBS.

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

4. The agency must ensure any component of the LST plan that may contain activities outside the scope of the LST trainer's expertise or licensure must be created by an appropriately licensed professional acting within his/her scope of practice.

    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 plan may be an agency staff member, contract staff member, or external licensed and certified professionals who are fully aware of duties conducted by LST trainers..

5. An agency must maintain a Class A or B Home Care Agency License issued by the Colorado Department of Public Health and Environment if that agency chooses to provide training on Personal Care as defined in one of the following listed regulations: Personal Care in the HCBS-CMHS, -EBD, or -CIH waivers as defined at Section 8.489.10; Personal Care in the HCBS-SLS waiver as defined at Section 8.500.94.B.12.

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

    a. An individual is qualified to be an LST trainer only if he/she is:

        i. A licensed health care professional with experience in providing functionally based assessments and skills training for individuals with disabilities;

        ii. An individual with a bachelor's degree and 1 year of experience working with individuals with disabilities;

        iii. An individual with an associate degree in a social service or human relations area and 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 3 years of experience providing services similar to LST services;

v. An individual with 4 years direct care experience teaching or working with needs of individuals with disabilities; or

vi. An individual with 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; and the provider must ensure that this individual receives member-specific training sufficient to enable the individual to competently provide LST to the member consistent with the LST Plan and the overall Service Plan.

a) For anyone qualifying as a trainer under these criteria, the provider must ensure that the trainer receives additional member-specific training sufficient to enable him/her to competently provide LST to the member that is consistent with the LST 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 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 must insure 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.

d. The provider employing an LST Trainer must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment as an LST Trainer. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of members. All costs related to obtaining a criminal background check shall be borne by the provider.

D. PROVIDER RESPONSIBILITIIES

1. Life Skills Training trainers directly support the member by designing with the member an individualized LST program service plan, and by implementing the plan through training with the member to develop and maintain his/her ability to independently sustain himself/herself physically, emotionally, socially and economically in the community.

2. The LST coordinator must review the member's LST program service plan to ensure it is designed to meet the needs of the member in order to enable him/her to independently sustain himself/herself physically, emotionally, and economically in the community; and

3. The LST coordinator must share the LST program service plan with the member's 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 service plan, or any portion of it, with other providers; and

4. Any component of the LST program service 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.

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

E. DOCUMENTATION

1. All LST providers must maintain a LST program service plan that includes:

a. Monthly skills training plans to be developed and documented; and

b. Skills training plans that include goals, goals achieved or failed, and progress made toward accomplishment of continuing goals.

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 8.130.2 and provided to supervisor(s), program monitor(s), auditor(s), and CDPHE surveyor(s) upon request. The LST service plan must include:

i. The start and end time/duration of service provision;

ii. The nature and extent of service;

iii. A description of LST activities, such as accompanying members to complicated medical appointments or to attend board, advisory and commissions meetings; and support with interviewing potential providers;

iv. Progress toward Service Plan goals and objectives; and

v. The provider's signature and date.

2. The LST program service plan shall be sent to the Case Management Agency responsible for the Service Plan on a monthly basis, or as requested by the Case Management Agency.

3. The LST program service plan shall be shared, with the member's permission, with the member's providers of other HCBS services that support or implement any service inclusions of the member's LST program that meet the needs of the member, enabling him/her to independently sustain himself/herself physically, emotionally, socially, and economically in the community.

F. 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. LST providers may furnish and bill separately for transportation, provided that they meet the state's provider qualifications for transportation services.

4. 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.

**8.553.4 HOME DELIVERED MEALS**

A. INCLUSIONS

1. Home Delivered Meals services include:

a. Individualized nutritional counseling and developing an individualized Nutritional Meal Plan, which specifies the member's nutritional needs, selected meal types, and instructions for meal preparation and delivery; and

b. Services to implement the individualized meal plan, including the member's requirements for preparing and delivering the meals.

c. The delivery of prepared nutritional meals.

B. SERVICE REQUIREMENTS

1. The member's 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 Service Plan. All Home Delivered Meal services shall be documented in the Service Plan.

3. Members may be approved for Home Delivered Meals for no more than 365 days.

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

5. Meals may include liquid, mechanical soft, or other medically necessary types.

6. Meals may be ethnically or culturally-tailored.

7. 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.

8. The provider 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.

9. 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.

10. The RD or RDN will review member's progress toward the nutritional goal(s) outlined in the member's Service Plan no less frequently than once per calendar quarter, and more frequently, as needed.

11. The RD or RDN shall make changes to the Nutritional Meal Plan if the quarterly assessment results show changes are necessary or appropriate.

12. 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 Service plan, as needed.

C. LIMITATIONS AND EXCLUSIONS

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. If items or services through which the member's need for Home Delivered Meal services can 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 of the member, only. Services provided to someone other than the member are not reimbursable.

D. PROVIDER STANDARDS

1. A licensed provider enrolled with Colorado Medicaid to provide Home Delivered Meal services 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. Must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, EBD, BI, or CIH waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98.

3. The provider 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. In accordance with 42 C.F.R Section 441.301(c)(1)(vi), providers of Home Delivered Meals for the individual, or those who have an interest in or are employed by the provider of Home Delivered Meals for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

6. The provider furnishing Home Delivered Meals services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment who would be tasked with furnishing Home Delivered Meals services. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of members. All costs related to obtaining a criminal background check shall be borne by the provider.

E. DOCUMENTATION

1. The provider shall maintain documentation in accordance with Section 8.130 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. A Signed authorization from appropriate licensed professional for 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.

F. 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.

**8.553.5 PEER MENTORSHIP**

A. INCLUSIONS

1. 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.

B. LIMITATIONS AND EXCLUSIONS

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.

3. Services or activities that are solely diversional or recreational in nature are excluded.

C. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Peer Mentorship services if:

a. The provider is a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State and holding a Certificate of Good Standing to do business in Colorado;

b. The provider conforms to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, -BI, or -SCI waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98;

c. The provider is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the provider's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; and

d. The provider cooperates with CDPHE compliance and complaint surveys, and obeys all CDPHE policies, regulations and directives regarding licensure.

e. In accord with 42 CFR 441.301(c)(1)(vi), providers of Peer Mentorship for the individual, or those who have an interest in or are employed by the provider of Peer Mentorship for the individual, must not provide case management, authorize services, or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management, authorize services, and/or develop person-centered service plans in a geographic area also provides HCBS.

f. 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.

2. The provider 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 the Service Plan;

c. Does not receive programming from the same residential location or day program location as the member; and

d. Has completed training from the provider agency consistent with core competencies. Core competencies are:

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.

3. The provider of peer mentorship services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment as a Peer Mentor, and on all staff who interface with Medicaid members. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of members. All costs related to obtaining a criminal background check shall be borne by the provider.

4. The provider must ensure that no staff member having contact with members is substantiated in the Colorado Adult Protection Services (CAPS) registry for mistreatment of an at-risk adult.

D. 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 8.130.2 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. Member’s Response as outlined in the Peer Mentorship Manual;

f. Progress toward Service Plan goals and objectives; and

g. Provider’s signature and date.

E. REIMBURSEMENT

1. Peer Mentorship services are reimbursed based on the number of units billed, with one 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 Service Plan

**8.553.6 TRANSITION SETUP**

A. SERVICE ACCESS AND AUTHORIZATION

1. To access Transition Setup, defined in Section 8.553.1, a member must be transitioning from an institutional setting 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.

   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 Service Plan.

3. Transition Setup is available in the Department's HCBS-BI Waiver under the Department's rule Section 8.515.2.A.17; HCBS-CMHS Waiver under the Department's rule Section 8.509.12.A.13; HCBS-DD Waiver under Section 8.500.5.A.10; HCBS-EBD Waiver under Section 8.485.31.N; HCBS-CIH Waiver under Section 8.517.1.A.14; and HCBS-SLS Waiver under Section 8.500.94.A.20.

B. 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 covers 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, 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 and use a community domicile, 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.

C. LIMITATIONS AND EXCLUSIONS

1. Transition Setup may be used to coordinate or purchase one-time, non-recurring expenses up to 30 days post-transition.

2. Transition Setup expenses must not exceed a total of $1,500 per eligible member. The Department may authorize additional funds above the $1,500 limit, not to exceed a total value of $2,000, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member.

3. Transition Setup does to substitute services available under the Medicaid State Plan, other waiver services, or other resources.

4. Transition Setup is not available for a transition to a living arrangement that is owned or leased by a waiver provider if the services offered as Transition Setup benefits are services furnished under the waiver.

5. Transition Setup does not include payment for room and board.

6. Transition Setup does not include rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes.

7. Transition Setup is not available for a transition to a living arrangement that does not match or exceed HUD certification criteria.

8. Transition Setup is not available when the person resides in a provider-owned or -controlled setting.

9. Transition Setup does not include appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television or video equipment, cable or satellite service, computers or tablets).

D. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Transition Setup services if:

a. The provider is 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; and

b. The provider is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations.

2. The provider must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, -BI, or -CIH waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98; and

3. In accord with 42 C.F.R Section 441.301(c)(1)(vi), providers of Transition Setup for the individual, or those who have an interest in or are employed by the provider of Transition Setup for the individual, must not provide case management, authorize services, or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management, authorize services, and/or develop person-centered service plans in a geographic area also provides HCBS.

4. The provider of Transition Setup services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment that would involve direct contact with Medicaid members. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of members. All costs related to obtaining a criminal background check shall be borne by the provider.

5. The provider shall ensure the product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

E. DOCUMENTATION

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

2. Providers must submit to the Case Management Agency the minimum documentation of the transition process, which includes:

a. A Transition Services Referral Form,

b. Release of Information (confidentiality) Forms, and

c. A Transition Setup Authorization Request Form.

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

F. 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 $1,500 per eligible member. The Department may authorize additional funds above the $1,500 limit, up to $2,000, when the member demonstrates additional needs, and if the expense(s) would ensure the member's health, safety and welfare.

3. Payment for Transition Setup shall be the lower of the billed charges or the maximum rate of reimbursement.

4. Reimbursement shall be made only for items or services described in the Service plan with an accompanying receipt.

5. 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.

**8.553.7 HOME DELIVERED MEALS POST-HOSPITAL DISCHARGE**

A. INCLUSIONS

1. Home Delivered Meals services include:

a. Individualized nutritional counseling and developing an individualized Nutritional Meal Plan, which specifies the member's nutritional needs, selected meal types, and instructions for meal preparation and delivery; and

b. Services to implement the individualized meal plan, including the member's requirements for preparing and delivering the meals.

c. The delivery of prepared nutritional meals.

B. SERVICE REQUIREMENTS

1. The member's 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 details 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 Service Plan. All Home Delivered Meal services shall be documented in the Service Plan.

3. Members 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.

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

5. Meals may include liquid, mechanical soft, or other medically necessary types.

6. Meals may be ethnically or culturally-tailored.

7. 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.

8. The provider 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.

C. LIMITATIONS AND EXCLUSIONS

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, for a maxiumum of 30 days.

3. Items or services through which the member's need for Home Delivered Meal services can 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 of the member, only. Services provided to someone other than the member are not reimbursable.

D. PROVIDER STANDARDS

1. A licensed provider enrolled with Colorado Medicaid to provide Home Delivered Meal services 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. Must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, EBD, BI, or CIH waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98.

3. The provider shall have all licenses 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. In accordance with 42 C.F.R Section 441.301(c)(1)(vi), providers of Home Delivered Meals for the individual, or those who have an interest in or are employed by the provider of Home Delivered Meals for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

6. The provider furnishing Home Delivered Meals services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment who would be tasked with furnishing Home Delivered Meals services. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of members. All costs related to obtaining a criminal background check shall be borne by the provider.

E. DOCUMENTATION

1. The provider shall maintain documentation in accordance with Section 8.130 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. A Signed authorization from appropriate licensed professional for 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, including person delivering the meal;

      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.

F. 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.

## 8.560 CLINIC SERVICES – CERTIFIED HEALTH AGENCIES

Clinic Services rendered by certified health agencies shall be a benefit of the Colorado Medical Assistance Program for categorically eligible individuals.

### 8.560.1 DEFINITIONS

For the purposes of this Section 8.560, the following definitions shall apply:

A. Certified health agency: a county/district health department, regional health department or local board of health established pursuant to part 5, 6, or 7 of article 1 of title 25, C.R.S., that is certified by the Colorado State Department of Health.

B. Nurse/Nurse practitioner: a registered professional nurse who is currently licensed to practice in the State of Colorado and who meets the qualifications established by the Nurse Practice Act.

C. Nurse-midwife: a registered professional nurse currently licensed to practice in the State of Colorado who meets the following requirements: is certified as a nurse-midwife by the American College of Nurse-Midwives; is authorized under state statute to practice as a nurse-midwife; and whose services are rendered pursuant to the Colorado Medical Practice Act.

D. Physician assistant/child health associate: a certified individual who performs under the supervision of a physician and meets the qualifications of the Colorado State Board of Medical Examiners.

E. Physician: a doctor of medicine, osteopathy, legally authorized to provide medicine or surgery in Colorado.

F. Medicaid primary care physician: a physician enrolled in the Primary Care Physician Program under the Colorado Medical Assistance Program.

G. Visit: a face-to-face encounter between a clinic patient and nurse/nurse practitioner/nurse-midwife, physician assistant/child health associate, or physician providing services reimburseable under the Medicaid Program. If a patient sees more than one health professional, or meets more than once with the same health professional, on the same day and at a single location, this shall be counted as one visit.

## 8.561 REQUIREMENTS FOR CERTIFICATION

A. Participating health agencies must be certified by the Colorado State Department of Health in accord with federal regulations 42 CFR 431.610, October 1991 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Manager, Health and Medical Services, Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203-1714. Certified health agencies performing laboratory services must be certified as a clinical laboratory in accordance with regulations cited at 8.660 through 8.666. Certified health agencies must obtain a certificate of waiver from the Health Care Financing Administration or its designated agency if the health agency only performs waivered tests as defined by Clinical Laboratory Improvement Amendments of 1988 (CLIA).

B. All certified health agencies and staff shall comply with all applicable federal, state and local regulations concerning the operation of such clinic services. These include but are not limited to the following: certification, organization, staffing, licensure of personnel, service provision responsibilities, maintenance of health records and program evaluation.

C. Termination of certification or non-renewal of certification will be determined by the Colorado State Department of Health.

**8.562 REQUIREMENTS FOR PARTICIPATION**

Health agencies providing clinic services must be certified by the Colorado State Department of Health, must enroll in the Medical Assistance Program and provide proof of their certification status in order to participate under Medicaid. The certification document must be attached to the Medical Assistance enrollment form. Medical Assistance enrollment and/or reimbursement cannot be accomplished without proof of certification on file with the State's fiscal agent for the effective date of enrollment and date of service for which reimbursement is claimed.

**8.563 BENEFITS AND LIMITATIONS**

Clinic Services are a benefit of the Medical Assistance Act in Colorado when:

A. The services are benefits of the Colorado Medicaid Program as determined by the Colorado State Department of Social Services;

B. The services which are performed are medically necessary;

C. The services are provided by certified health agencies;

D. The services which are performed are within the scope of the providers' Medical and/or Nurse Practice Acts;

E. The services are provided by a registered nurse, qualified nurse practitioner, or certified nurse-midwife or by a physician or physician's assistant (including child health associates) certified by the Colorado State Board of Medical Examiners;

F. The services provided are obstetrical services which are benefits of the Medicaid program; or

G. The services provided are EPSDT medical screening services which meet the requirements set forth in sections 8.285.02 through 8.287.01.

**8.564 BILLING PROCEDURES**

A. Certified health agencies providing clinic services must bill the Medical Assistance Program directly using the designated billing method and the prescribed procedure codes recognized by the Colorado State Department of Social Services. The amount of the provider's usual and customary charges to the general public will be billed if applicable.

B. Obstetrical services and adjunctive services, except for EPSDT medical screenings, must be billed directly as described in 10 C.C.R. 2505-10, Section 8.040.2.

C. EPSDT medical screening services must be billed directly on the EPSDT Screening/Claim Form.

**8.565 REIMBURSEMENT**

Reimbursement shall be made according to the following:

A. Payment for benefit services shall be in accord with the physician reimbursement policies as cited in Section 8.200 et seq.

B. Each certified health agency will be reimbursed for only those services performed for which it is certified and for only one visit per recipient per day.

C. Reimbursement for injectable vaccines obtained through the Infant Immunization Program is limited to the maximum allowed administrative fee.

D. A health agency must be certified on any date for which reimbursement is being claimed. If reimbursement is claimed for a date of service on which the health agency is not certified, reimbursement shall be denied.

**8.566 APPEALS**

Provider grievances and appeals, resulting from State actions under this section of regulations, shall be handled in accordance with existing appeals regulations delineated in Sections 8.049 through 8.051.44.

**8.567 CERTIFIED HEALTH AGENCY/PHYSICIAN RELATIONSHIP**

A. Obstetrical services require referral from the Medicaid Primary Care (PCP) or “Lock-In” physician. The certified agency will contact the PCP to obtain the appropriate referral for obstetrical services.

B. EPSDT medical screenings require referral from the Medicaid Primary Care (PCP) or “Lock-In” physician. The certified agency will contact the PCP to obtain the appropriate referral for EPSDT Medical screening services.

C. Medical support and approval for the policies and procedures of the local certified health agency's Well Child Clinics and Prenatal Clinics may be provided by the agency health officer, medical director or other physician (pediatrician, family practitioner or obstetrician) agreed upon by the public health nursing staff and their health officer. A physician must sign and annually review the agency's emergency procedures for reactions to biologicals.

D. The certified health agency shall assure that a physician is available during agency hours by direct means of communication for assistance in emergencies and for consultation and referral if medical diagnosis and/or treatment is needed. This requirement may be satisfied by agreements with one or more physicians. Whenever possible, the certified health clinic practitioner will interact with the client's primary care physician when medical consultation is needed and will provide the primary care physician a copy of each EPSDT medical screening and obstetrical service record.

## 8.570 AMBULATORY SURGERY CENTERS

### 8.570.1 DEFINITIONS

Ambulatory Surgery Center (ASC) means an entity that operates exclusively for the purpose of furnishing surgical services for its clients that do not require hospitalization. An ASC may be independent or part of a hospital, but only if the building space utilized by the ASC is physically, administratively, and financially independent and distinct from other operations of the hospital.

CMS means the Centers for Medicare and Medicaid Services.

The Department refers to the Colorado Department of Health Care Policy and Financing.

Inpatient Basis in Hospitals means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by the Hospital for the care and treatment of inpatients and are provided in the Hospital by or under the direction of the physician.

### 8.570.2 REQUIREMENTS FOR PARTICIPATION

8.570.2.A. An ASC shall be certified by CMS to participate in the Medicare program as an ASC and be licensed by the Colorado Department of Public Health and Environment as an ASC.

### 8.570.3 COVERED SERVICES AND LIMITATIONS

8.570.3.A. Covered services are those surgical and other medical procedures that:

1. Are ASC procedures that are grouped into categories corresponding to the CMS defined groups.

2. Are commonly performed on an inpatient basis in hospitals, but may be safely performed in an ASC.

3. Are limited to those requiring a dedicated operating room (or suite), and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room.

8.570.3.B. Covered surgical procedures are limited to those that do not generally exceed:

1. A total of 4 hours recovery or convalescent time.

8.570.3.C. If the covered surgical procedures require anesthesia, the anesthesia must be:

1. Local or regional anesthesia; or

2. General anesthesia.

### 8.570.4. DENTAL PROCEDURES

1. Qualifying clients may receive covered and medically necessary dental services in an ASC when those services cannot be delivered safely and effectively in a private office.

### 8.570.5 NON-COVERED SERVICES

8.570.5.A Non-covered services are those services that:

1. Are not commonly performed in an ASC;

2. May safely be performed in a physician's office;

3. Generally result in extensive blood loss;

4. Require major or prolonged invasion of body cavities;

5. Directly involve major blood vessels;

6. Are generally emergency or life-threatening in nature;

7. Pose a significant safety risk to clients or are expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay) when furnished in an ASC; or,

8. Are not listed in the annual ASC billing manual.

**8.570.6. CLIENT ELIGIBILITY**

Eligible Clients include any Client enrolled in Colorado Medicaid for whom a covered ASC service is a medical necessity as defined at 10 CCR 2505-10 Section 8.076.1.8.

**8.570.7. PRIOR AUTHORIZATION**

The physician performing the surgery shall be responsible for obtaining all necessary Prior Authorizations for those procedures requiring pre-procedure approval by the Department.

**8.570.8 REIMBURSEMENT**

8.570.8.A For payment purposes, ASC surgical procedures are placed into groupers. The Health Care Procedural Coding System (HCPCS) is used to identify surgical services.

8.570.8.B Reimbursement for approved surgical procedures shall be allowed only for the primary or most complex procedure. No reimbursement is allowed for multiple or subsequent procedures. No reimbursement shall be allowed for services not included on the Department approved list for covered services. Approved surgical procedures identified in the ASC groupers shall be reimbursed a facility fee at the lower of the following:

1. Submitted charges; or

2. Department approved list for covered services.

**8.570.9 ALLOWABLE COSTS**

8.570.9.A The services payable under this rule are facility services furnished to clients in connection with covered surgical procedures specified in Section 8.570.3.

1. Services and items reimbursed as part of the facility fee include, at a minimum, the following:

   a. Use of the facilities where the surgical procedures are performed.

   b. Nursing, technician, and related services.

c. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures.

d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.

e. Administrative, record keeping and housekeeping items and services.

f. Materials for anesthesia.

g. Intra-ocular lenses (IOLs).

h. Supervision of the services of an anesthetist by the operating surgeon.

2. Services and items that are not reimbursed as part of the facility fee, but that may be reimbursed separately include the following:

a. Physician services.

b. Anesthetist services.

c. Laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure.)

d. Prosthetic devices (except IOLs).

e. Ambulance services.

f. Leg, arm, back and neck braces.

g. Artificial limbs.

h. Durable medical equipment for use in the client's home.

### 8.571 CLINIC SERVICES - AMBULATORY SURGERY CENTER, PHYSICIAN PRIOR AUTHORIZATION

The physician performing the surgery shall be responsible for obtaining all necessary Prior Authorizations for those procedures requiring pre-procedure approval by the Department.

## 8.580 DURABLE MEDICAL EQUIPMENT – OXYGEN AND OXYGEN EQUIPMENT

### 8.580.1 DEFINITIONS

8.580.1.A. Certificate of Medical Necessity means the Medicare CMN-484 Oxygen form or the Colorado Medicaid Certificate of Medical Necessity for Oxygen Benefits form.

8.580.1.B. Concentrator means an oxygen delivery system that operates electrically to concentrate oxygen from room air.

8.580.1.C. Hypoxemia means deficient oxygenation of blood.

8.580.1.E Nursing Facility means nursing facilities, intermediate nursing facilities, and skilled nursing facilities that receive facility payment reimbursement for care.

8.580.1.F. Oxygen Concentrator is the same as a concentrator.

8.580.1.G. Oxygen Delivery System means the method by which oxygen is delivered to the client.

8.580.1.H. Portable Oxygen System means an oxygen delivery system, utilizing either concentrators or tanks, that can be easily moved with the client on a frequent basis.

8.580.1.I. Post-Acute Oxygen Therapy means providing short term oxygen lasting three months or less to address a client's acute condition that is expected to resolve.

8.580.1.J. Stationary Oxygen Delivery System means an oxygen delivery system that cannot be easily moved with the client on a frequent basis and does not concentrate oxygen from room air.

8.580.1.K. Ventilator means a device to assist or control ventilation for a client who is unable to maintain spontaneous ventilation unassisted.

### 8.580.2 CLIENT ELIGIBILITY

8.580.2.A. All Colorado Medicaid clients are eligible for oxygen therapy and oxygen equipment deemed medically necessary, as defined in Section 8.076.1.8.

### 8.580.3 PROVIDER ELIGIBILITY

**8.580.3.A.** Ordering, Prescribing, Referring (OPR) Providers

1. The following providers are eligible to order, prescribe, or refer oxygen therapy and oxygen equipment when the provider is enrolled with Colorado Medicaid and licensed by the Colorado Department of Regulatory Agencies, or the licensing agency of the state in which they are licensed:

    a. Doctors of Medicine (MD)

    b. Doctors of Osteopathy (DO)

    c. Physician Assistants

    d. Nurse Practitioners

**8.580.3.B.** Rendering Providers

1. The following providers are eligible to render oxygen therapy and oxygen equipment when the provider is enrolled with Colorado Medicaid and licensed by the licensing agency of the state in which they do business:

    a. Durable Medical Equipment (DME) Providers enrolled in Colorado Medicaid, otherwise referred to as “suppliers.”

**8.580.4 PLACES OF SERVICES**

8.580.4.A. Eligible Places of Services

1. The following places are eligible for a client to receive oxygen and oxygen equipment:

    a. Home

    b. Nursing Facilities and group homes

    c. Intermediate care facilities for individuals with intellectual disabilities

    d. Hospitals

        i. Oxygen contents and oxygen equipment provided to hospitalized clients must be provided by the hospital and cannot be submitted for direct payment by the supplier. Reimbursement for oxygen and oxygen equipment in hospitals is provided under Section 8.580.8.A.5.

**8.580.5 COVERED SERVICES AND EQUIPMENT**

**8.580.5.A.** The following clients require a prescription for oxygen therapy and oxygen equipment, but are otherwise exempt from the coverage requirements of this subsection at Section 8.580.5:

1. Ventilator-dependent clients; and

2. Clients covered under the child health component of Medicaid known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT), as identified in Section 8.280.

8.580.5.B. Post-Acute Oxygen Therapy

1. Post-Acute Oxygen Therapy may be provided to clients for up to ninety days with a prescription from an OPR provider identified in Section 8.580.3.A.

    a. Post-Acute Oxygen Therapy requires a documented assessment of Hypoxia.

**8.580.5.C. Long Term Oxygen Therapy Certificate of Medical Necessity**

1. Long Term Oxygen Therapy may be provided to clients for greater than ninety days with a prescription from an OPR provider identified in Section 8.580.3.A and a Certificate of Medical Necessity.

    a. The Certificate of Medical Necessity must:

        i. Be obtained by the rendering provider within one hundred twenty days of the client beginning oxygen therapy;

ii. Be signed by a physician or licensed professional responsible for care of the client, which includes the medical director of a Nursing Facility;

iii. Include the most recent blood gas study or oxygenation assessment, obtained within thirty days of the initial oxygen provision date on the Certificate of Medical Necessity.

b. Recertification of the CMN required under Section 8.580.5.C.1 is required every twelve months or when the client's condition changes, whichever comes first. Pursuant to Public Law 116-127, the Families First Coronavirus Response Act, § 6008, continued coverage of oxygen is required during the Coronavirus Disease 2019 (COVID-19) public health emergency as it was covered prior the emergency. For the duration of the COVID-19 public health emergency, the CMN recertification required every twelve months under this section, and the requirement for annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii), is suspended. Clients must obtain recertification as soon as practicable after the COVID-19 public health emergency ends, as declared by the President of the United States on March 13, 2020, and every twelve months thereafter.

i. Clients certified for twenty-four consecutive months no longer require a Certificate of Medical Necessity for oxygen, but still require a documented annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii). Documented annual reviews include a renewed prescription for oxygen or other medical record documentation.

2. Suppliers must have a completed and current Certificate of Medical Necessity on file to support claims for oxygen therapy and oxygen equipment for non-ventilator dependent clients aged twenty and older requiring long term oxygen therapy lasting ninety days or more. For clients certified for twenty-four consecutive months, the most recent certified Certificate of Medical Necessity and the most recent annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii) must be on file.

8.580.5.D. Portable Oxygen Systems

1. Clients aged twenty-one and above may qualify for a Portable Oxygen System either by itself or to use in addition to a Stationary Oxygen Delivery System if the following requirements are met:

a. The Section 8.580.5.B or Section 8.580.5.C requirements are satisfied, and

b. The medical documentation indicates the client is mobile in their residence or mobile in the community and would benefit from the use of a Portable Oxygen System.

2. Portable Oxygen Systems are not covered for clients who qualify for oxygen solely based on blood gas studies obtained during sleep unless the client resides in a Nursing Facility.

3. If a client resides in a Nursing Facility and receives portable oxygen while sleeping outside their room, the client should be assessed for continuous oxygen need.

**8.580.6 PRIOR AUTHORIZATION REQUIREMENTS**

**8.580.6.A.** There are no prior authorization requirements for oxygen therapy and oxygen equipment.

8.580.7.A NON-COVERED SERVICES

1. Oxygen therapy and oxygen equipment is not covered if a client exhibits any of the following conditions:

    a. Chronic angina pectoris in the absence of Hypoxemia.

    b. Breathlessness without cor pulmonale or evidence of Hypoxemia.

8.580.8.A REIMBURSEMENT

1. To receive reimbursement, provider records must include, but are not limited to:

    a. All oxygen therapy and oxygen equipment orders, prescriptions, and Certificates of Medical Necessity;

        i. Oxygen therapy and oxygen equipment provided for Post Acute Oxygen Therapy of less than ninety days does not require a Certificate of Medical Necessity, but does require a documented assessment of Hypoxia under Section 8.580.5.B.1.a.

    b. Record of oxygen-related items provided;

    c. Documentation that the client, or the client's caregiver, was provided with manufacturer instructions, warranty information, service manual, and operating instructions for the rendered oxygen therapy and oxygen equipment.

2. Medicaid will not reimburse as primary payer for DME oxygen for clients that are:

    a. Dually eligible for Medicare and Medicaid,

    b. Aged twenty-one or above, and

    c. Not receiving benefits in a Nursing Facility or intermediate care facility for individuals with intellectual disabilities.

3. Medicaid will not reimburse as a primary payer for DME oxygen for clients that are:

    a. Dually eligible for Medicare and Medicaid,

    b. Aged twenty-one or above, and

    c. Receiving Medicare-covered skilled nursing services in a Nursing Facility.

4. Oxygen therapy and oxygen equipment provided in a client's home:

    a. Suppliers must directly bill the Department for medically necessary liquid or gaseous oxygen equipment provided in a client's home or place of residence, not to include Nursing Facilities.

b. Reimbursement to a rendering provider for Oxygen Therapy or Oxygen Equipment must be the lower of the provider's billed charge or the Department's fee schedule.

5. Oxygen therapy and oxygen equipment provided to hospitalized clients

a. Oxygen therapy and oxygen equipment, when medically necessary and prescribed by an OPR provider for any form of oxygen for a client a hospital setting, inpatient or outpatient, must be provided by the hospital and is included in the Medicaid payment for inpatient hospital services.

6. Oxygen therapy and oxygen equipment provided to Nursing Facility and group home clients

a. Suppliers must bill the Department directly for medically necessary liquid or gaseous oxygen therapy, and oxygen equipment needed for the administration of liquid or gaseous oxygen, if provided to clients residing in Nursing Facilities that are reimbursed at a per diem amount.

b. Oxygen Concentrators for use by clients residing in a Nursing Facility or group home being reimbursed at a per diem rate must be provided in one of the following ways:

i. Oxygen Concentrators purchased by the Nursing Facility or group home must be included in the facility cost report and reimbursed through the per diem rate. All necessary oxygen-related supplies must be provided by the facility in accordance with Section 8.441.5.K.

ii. Clients residing in Nursing Facilities or group homes that do not purchase oxygen Concentrators must obtain equipment and supplies from an authorized supplier. The supplier must provide equipment, oxygen and supplies for use by a specific client, as ordered by the client's OPR provider, and must bill on the state approved form.

c. Nursing Facilities and group homes must provide the following information in a certification statement to suppliers within twenty (20) days of the date the supplier delivers the oxygen therapy or oxygen equipment:

i. The name and Medicaid identification number for all Medicaid clients provided liquid or gaseous oxygen, or the equipment or supplies necessary for administration by the supplier;

ii. An indication of whether any Medicaid clients identified in (i) have Medicare Part A or Medicare Part B, or any other third-party resources;

iii. The name and state identification number for all Medicaid clients identified in (i) that utilize an oxygen concentrator rented, but not purchased, from the supplier. This applies only to clients in Nursing Facilities or group homes that do not purchase oxygen Concentrators;

iv. A certification guaranteeing that oxygen therapy and oxygen equipment obtained from the supplier was used only by the individual Medicaid client for which it was supplied. Where centralized oxygen systems are utilized, each Medicaid client's oxygen usage must be documented and identified in the certification statement in liters.

d. Rendering providers (suppliers) must bill the Department for oxygen therapy and oxygen equipment based on the information provided by the Nursing Facility or group home in the Certification Statement, as required by Section 8.580.8.A.6.c. A rendering provider's reimbursement rate for oxygen therapy and oxygen equipment must be the lower of the provider's billed charges or the Department's fee schedule.

## 8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

### 8.590.1 DEFINITIONS

A. Abuse, for the purposes of Section 8.590, means the intentional destruction of or damage to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies that results in the need for repair or replacement.

B. Billing Manual, for the purposes of Section 8.590, means a reference document that assists providers with appropriately billing claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.

C. Cochlear Implant or cochlear prosthesis means an electrode or electrodes surgically implanted in the cochlea which are attached to an induction coil buried under the skin near the ear, and the associated unit which is worn on the body.

D. Complex Rehabilitation Technology means individually configured manual Wheelchair systems, power Wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designated options and accessories, which qualify as Durable Medical Equipment that:

1. Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living, including employment, identified as medically necessary to promote mobility in the home and community or prevent hospitalization or institutionalization of the member;

2. Are primarily used to serve a medical purpose and generally not useful in the absence of disability, illness or injury; and

3. Require certain services provided by a qualified Complex Rehabilitation Technology Supplier to ensure appropriate design, configuration, and use of such items, including patient evaluation or assessment of the client by a Qualified Health Care Professional, and that are consistent with the member's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

E. Complex Rehabilitation Technology Professional means an individual who is certified by the Rehabilitation Engineering and Assistive Technology Society of North America or other nationally recognized accrediting organizations as an assistive technology professional.

F. Complex Rehabilitation Technology Supplier means a provider who meets all the requirements of Section 8.590.5.D.

G. Disposable Medical Supplies (Supplies) means health care related items that are consumable, disposable, or cannot withstand repeated use by more than one individual. Supplies are required to address an individual medical disability, illness or injury.

H. Durable Medical Equipment (DME) means items, including Prosthetics and Orthotics, that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

I. Facilitative Device means DME with a retail price equal to or greater than one hundred dollars that is exclusively designed and manufactured for a member with disabilities to improve, maintain or restore self-sufficiency or quality of life through facilitative technology. Facilitative Devices do not include Wheelchairs.

J. Financial Relationship means any ownership interest, investment interest or compensation arrangement between a provider, or their officers, directors, employees or Immediate Family Members of the provider, and the entity. An ownership or investment interest may be reflected in equity, debt, or other instruments and includes, but is not limited to, mortgages, deeds of trust, notes or other obligations secured by either entity.

K. Hearing Aid means a wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories thereto, including ear molds but excluding batteries and cords.

L. Immediate Family Member means any spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, sibling or stepsibling, in-laws, grandparents and grandchildren.

M. Medical Necessity, for the purposes of Section 8.590, means the definition as described at 10 CCR 2505-10, Section 8.076.1.8.

N. Misuse means failure to maintain or the intentional utilization of DME and Supplies in a manner not prescribed, recommended or appropriate that results in the need for repairs or replacement. Misuse also means DME and Supplies used by someone other than the member for whom it was prescribed.

O. Prosthetic or Orthotic Device means replacement, corrective or supportive devices that artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

P. Qualified Health Care Professional means a licensed physical therapist, a licensed occupational therapist, or other licensed health care professional who performs specialty evaluations within his/her scope of practice and who has no Financial Relationship with a Complex Rehabilitation Technology Supplier.

Q. Related Owner means an individual with 5% or more ownership interest in a business and one entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business.

R. Related Party means a provider who is associated or affiliated with, or has control of, or is controlled by the organization furnishing the DME and Supplies. An owner related individual shall be considered an individual who is a member of an owner's Immediate Family.

S. Speech Generating Device (SGD) means a device that provides multiple methods of message formulation and is used to establish, develop or maintain the ability to communicate functional needs. These devices are electronic and computer based and can generate synthesized (computer-generated) or digitized (natural human) speech output for expressive communication.

T. Start Of Service means the date that the ordering practitioner signs the written order for durable medical equipment following the face-to-face encounter with the member.

U. Wheelchair means any wheelchair or scooter that is motor driven or manually operated for the purposes of mobility assistance, purchased by the Department or donated to the member.

V. Wrongful Disposition means the mismanagement of DME and Supplies by a member by selling or giving away the item reimbursed by the Department.

**8.590.2 BENEFITS**

8.590.2.A. All covered DME and Supplies shall, at a minimum, be:

1. A Medical Necessity; and

2. Prescribed by a physician and, when applicable, recommended by an appropriately licensed practitioner.

3. At-home over-the-counter COVID-19 tests may be prescribed by a licensed pharmacist.

8.590.2.B. DME and Supplies for Members Residing in Facilities

1. DME and Supplies for members residing in a hospital, nursing facility or other facility, are provided by those facilities and reimbursed as part of the per diem rate. DME and Supplies shall not be separately billed, except under the following circumstances:

   a. The member is within fourteen days of discharge, and

   b. Prior authorization or training are needed to assist the member with equipment usage, and

   c. The equipment is needed immediately upon discharge from the facility.

2. Repairs and modifications to member owned DME, not required as part of the per diem reimbursement, shall be provided to members residing in a hospital, nursing facility or other facility receiving per diem Medicaid reimbursement.

3. Prosthetic or Orthotic Devices may be provided to members residing in a hospital, nursing facility or other facility receiving per diem Medicaid reimbursement if Prosthetic or Orthotic benefits are not included in the facility's per diem rate.

8.590.2.C. DME and Supplies shall not be duplicative or serve the same purpose as items already utilized by the member unless it is medically required for emergency or backup support. Backup equipment shall be limited to one.

8.590.2.D. All DME and Supplies reimbursed for by the Department shall become the property of the member unless the member and provider are notified otherwise by the Department at the time of purchase.

8.590.2.E. Rental equipment shall be provided if the Department determines it to be cost effective and Medically Necessary.

8.590.2.F. Supplies shall be for a specific purpose, not incidental or general purpose usage.

8.590.2.G. The following DME and Supplies categories are benefits for members regardless of age, and include but are not limited to:

1. Ambulation devices and accessories including but not limited to canes, crutches or walkers.

2. Bath and bedroom safety equipment.

3. Bath and bedroom equipment and accessories including, but not limited to, specialized beds and mattress overlays.

4. Manual or power Wheelchairs and accessories.

5. Diabetic monitoring equipment and related disposable supplies.

6. Elastic supports/stockings.

7. Blood pressure, apnea, blood oxygen, pacemaker and uterine monitoring equipment and supplies.

8. Oxygen and oxygen equipment in the member's home, a nursing facility or other institution. The institutional oxygen benefit is fully described in 10 C.C.R. 2505-10, Sections 8.580, and 8.585.

9. Transcutaneous and/or neuromuscular electrical nerve stimulators (TENS/NMES) and related supplies.

10. Trapeze, traction and fracture frames.

11. Lymphedema pumps and compressors.

12. Specialized use rehabilitation equipment.

13. Oral and enteral formulas and supplies.

14. Parenteral equipment and supplies.

15. Environmental controls for a member living unattended if the controls are needed to assure medical safety.

16. Facilitative Devices.

    a. Telephone communication devices for the hearing impaired and other facilitative listening devices, except hearing aids, and Cochlear Implants.

    b. Computer equipment and reading devices with voice input or output, optical scanners, talking software, Braille printers and other devices that provide access to text.

    c. Computer equipment with voice output, artificial larynges, voice amplification devices and other alternative and augmentative communication devices.

    d. Voice recognition computer equipment software and hardware and other forms of computers for persons with disabilities.

    e. Any other device that enables a person with a disability to communicate, see, hear or maneuver including artificial limbs and orthopedic footwear.

17. Complex Rehabilitation Technology.

8.590.2.H. The following DME are benefits to members under the age of 21:

1. Hearing aids and accessories.

2. Phonic ear.

3. Therapy balls for use in physical or occupational therapy treatment.

4. Selective therapeutic toys.

5. Computers and computer software when utilization is intended to meet medical rather than educational needs.

6. Vision correction unrelated to eye surgery.

8.590.2.I. The following Prosthetic or Orthotic Devices are benefits for members regardless of age:

1. Artificial limbs.

2. Facial Prosthetics.

3. Ankle-foot/knee-ankle-foot orthotics.

4. Recumbent ankle positioning splints.

5. Thoracic-lumbar-sacral orthoses.

6. Lumbar-sacral orthoses.

7. Rigid and semi-rigid braces.

8. Therapeutic shoes.

9. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements.

10. Specialized eating utensils and other medically necessary activities of daily living aids.

11. Augmentative communication devices and communication boards.

8.590.2.J. Repairs and replacement parts are covered under the following conditions:

1. The item was purchased by Medicaid; or

2. The item is owned by the member, member's family or guardian; and

3. The item is used exclusively by the member; and

4. The item's need for repair was not caused by member Misuse or Abuse; and

5. The item is no longer under the manufacturer warranty.

8.590.2.K. The minimum replacement timeline for a Speech Generating Device is five years.

1. Stolen devices may be replaced within the five-year timeline; however, the client is limited to one-time replacement due to theft, and a police report must be provided for verification of the incident.

2. Replacement will not be granted within the five-year timeline for devices that are damaged, lost, misused, abused or neglected.

8.590.2.L. Repairs, replacement, and maintenance shall be:

1. Based on the manufacturer's recommendations, and

2. Performed by a qualified rehabilitation professional, and

3. Allowed on the member's primary equipment or one piece of backup equipment.

4. Multiple backup equipment will not be repaired, replaced or maintained.

8.590.2.M. If repairs are frequent and repair costs approach the purchase price of new equipment, the provider shall make a request for the purchase of new equipment. The prior authorization request shall include supporting documentation explaining the need for the replacement equipment and the cost estimates for repairs on both the old equipment and the new equipment purchase.

8.590.2.N. Supplies are a covered benefit when related to the following:

1. Surgical, wound or burn care.

2. Syringes or needles.

3. Bowel or bladder care.

4. Incontinence.

5. Antiseptics or solutions.

6. Gastric feeding sets and supplies.

7. Tracheostomy and endotracheal care supplies.

8. Diabetic monitoring.

8.590.2.O. Quantities of Supplies shall not exceed one month's supply unless they are only available in larger quantities as packaged by the manufacturer.

8.590.2.P. Medicaid members for whom Wheelchairs, Wheelchair component parts and other specialized equipment were authorized and ordered prior to enrollment in a Managed Care Organization, but delivered after the Managed Care Organization enrollment shall be the responsibility of the Department. All other DME and Supplies for members enrolled in a Managed Care Organization shall be the responsibility of the Managed Care Organization.

8.590.2.Q. Items, for the purposes of Rule 8.590, that are used for the following are not a benefit to a member of any age:

1. Routine personal hygiene.

2. Education.

3. Exercise.

4. Participation in sports.

5. Cosmetic purposes.

8.590.2.R. For members age 21 and over, the following items are not a benefit:

1. Hearing aids and accessories.

2. Phonic ears.

3. Therapeutic toys.

4. Vision correction unrelated to eye surgery.

8.590.2.S. Rental Policy.

1. The Department may set a financial cap on certain rental items. The monetary price for those items shall be determined by the Department and noted in the fee schedule. The provider is responsible for all maintenance and repairs as described at 8.590.4.N-P, until the cap is reached.

2. Upon reaching the capped amount, the equipment shall be considered purchased and shall become the property of the member. The provider shall give the member or caregiver all applicable information regarding the equipment. The equipment shall not be under warranty after the rental period ends.

3. The rental period may be interrupted, for a maximum of sixty consecutive days.

   a. If the rental period is interrupted for a period greater than sixty consecutive days, the rental period must begin again. The interruption must be justified, documented by a physician, and maintained by the provider as described at 10 CCR 2505-10, Section 8.590.4.E.

4. If the member changes providers, the current rental cap remains in force.

**8.590.3 PRIOR AUTHORIZATION**

8.590.3.A. Selected DME and Supplies require prior authorization approval. All items requiring prior authorization are listed in the Billing Manual.

8.590.3.B. Prior authorization shall not be required for Medicare covered crossover claims.

8.590.3.C. Prior authorization shall be required for members who have other primary insurance besides Medicare.

8.590.3.D. Prior authorization requests shall, include the following information:

1. A full description of the item(s).

2. The requested number of items.

3. A full description of all attachments, accessories and/or modifications needed to the basic item(s).

4. The effective date and estimated length of time the item(s) will be needed.

5. The medical diagnosis, prognosis for improvement or deterioration, previous and description of current treatments and any other clinical information necessary to establish Medical Necessity for the member.

6. Descriptions of any specific physical limitations, or current functional needs, the member may have that are relevant to the prior authorization consideration.

7. The member's prescribing physician's, primary care physician's and provider's name and identification numbers.

8. The serial numbers for all Wheelchair repairs.

9. The prescribing physician's signature. The prescribing physician can either sign the authorization or attach a written prescription or letter of Medical Necessity to the authorization.

8.590.3.E. Prior authorization requests for DME must meet the prior authorization criteria at 10 CCR 2505-10, Section 8.590.3.D, and the applicable DME or Supply specific criteria below:

1. Prior authorization requests for Speech Generating Devices shall include an communication assessment, made by a licensed speech-language pathologist, which provides documentation of:

   a. The member's communication limitations and skills; and

   b. A history of communication-related therapies; and

   c. A description of any trials required for the recommended device, including how each device trial met or failed to meet the member's functional communication needs; and

   d. Evidence that alternative, natural communication methods have been ineffective; and

   e. The member's ability to operate the device both cognitively and physically; and

   f. Expected improvement in the member's independence or personal safety, ability to communicate medical and basic needs, provide feedback on treatment or therapy programs, and prevent secondary impairments.

8.590.3.F. Diagnostic and clinical information shall be completed prior to the physician's signature. The provider shall not complete or add information after the physician has signed the document.

8.590.3.G. Requests for prior authorization shall be submitted in a timely fashion. Requests for prior authorization submitted with a begin date in excess of three months prior to the date of submission shall include additional, updated documentation indicating the continued Medical Necessity of the request. Retroactive approval beyond three months without such documentation shall be considered only in cases of member retroactive program eligibility.

8.590.3.H. Approval of a prior authorization does not guarantee payment or constitute a waiver of any claims processing requirements including, but not limited to, eligibility and timely filing.

**8.590.4 PROVIDER RESPONSIBILITIES**

8.590.4.A. Providers shall issue express warranties for Wheelchairs and Facilitative Devices and shall assure that any refund resulting from the return of a Wheelchair or other Facilitative Device is returned to the Department in compliance with Sections 6-1-401 to 6-1-412, C.R.S. (2016) and Sections 6-1-501 to 6-1-511, C.R.S. (2016). Sections 6-1-401 to 6-1-412 and 6-1-501 to 6-1-511, C.R.S. (2016). Sections 6-1-401 to 6-1-412 and 6-1-501 to 6-1-511, C.R.S. (2016) are hereby incorporated by reference. Such in corporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S. (2016), the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado.

8.590.4.B. The Provider shall implement a system that supports member autonomy and describes how equipment will be serviced and maintained, routine follow-up and response procedures to prevent any interruption of services to the members. This system shall include provisions describing how service and repairs may occur at the member's location when appropriate.

1. Providers shall furnish the member with written information at the time of sale on how to access service and repair.

8.590.4.C. The Provider shall implement and maintain a process for honoring all warranties expressed and implied under applicable State laws.

8.590.4.D. Providers of custom Wheelchairs, seating products and any other DME shall be able to appropriately assess and provide adequate repairs, adjustment and service by qualified rehabilitation professionals for all products they distribute.

8.590.4.E. Providers shall maintain the following for all items provided to a member:

1. Physician prescriptions.

2. Approved prior authorization requests.

3. Additional documentation received from physicians or other licensed practitioners.

4. Documentation that the member or caregiver have been provided with the following:

    a. Manufacturer's instructions.

    b. Warranty information.

    c. Registration documents.

    d. Service manual.

    e. Operating guides.

5. Documentation on all reimbursed equipment, which shall include:

    a. Manufacturer's name and address.

    b. Date acquired.

    c. Acquisition cost.

d. Model number.

e. Serial number.

f. Accessories, attachments or special features included in the item.

6. Providers shall verify that equipment requiring repairs belongs to the presenting member.

7. Providers shall retain all documentation for a period of six years.

8. Providers shall provide a copy of all documentation to a member or his/her representative, if requested.

8.590.4.F. Providers shall be responsible for delivery of and instructing the member on the proper use of the ordered/authorized equipment or supplies appropriate for the stated purpose consistent with the requirements, goals and desired outcomes at the time of the prescription and delivery.

8.590.4.G. The provider shall be responsible for member evaluation, wheelchair measurements and fittings, member education, adjustments, modifications and delivery set-up installation of equipment in the home. If modifications require the provider to fabricate customized equipment or orthotics to meet member needs, the provider shall justify the necessity and the cost of additional materials of the modifications. Modifications shall not alter the integrity, safety or warranty of the equipment.

8.590.4.H. The provider shall pick-up inappropriate or incorrect items within five business days of being notified. The provider shall not bill the Department for items known to be inappropriate or incorrect and awaiting pick-up. The provider shall submit a credit adjustment to the Department within twenty business days following the pick-up date if a claim was submitted prior to notification an item was inappropriate or incorrect.

8.590.4.I. Providers shall confirm continued need for disposable supplies with the member or caretaker prior to supply shipment.

8.590.4.J. All purchased equipment shall be new at the time of delivery to the member unless an agreement was reached in advance with the member and Department.

8.590.4.K. Providers shall provide DME and Supplies, repairs and all other services in the same manner they provide these services to non-Medicaid clients.

8.590.4.L. Providers shall ensure the equipment provided will be warranted in accordance with the manufacturer’s warranty. The provider shall not bill Medicaid or the member for equipment, parts, repairs, or other services covered by the warranty.

8.590.4.M. The following requirements shall apply to warranted items:

1. The provider shall provide adequate repairs, adjustments and services by appropriately trained technicians for all products they distribute.

2. The provider shall complete services or repairs in a timely manner and advise the member on the estimated completion time.

3. The provider shall arrange for appropriate alternative, like equipment in the absence of member owned backup equipment. The provider shall provide the alternative equipment at no cost. If the backup equipment is not available as loan equipment, the provider shall arrange for a temporary equipment rental through the Department.

4. The provider shall exclude from warranty provisions, replacement or repairs to equipment that are no longer able to meet member needs due to changes in anatomical and/or medical condition that occurred after purchase.

5. The provider may refuse warranty services on items for which there have been documented patterns of specific member Misuse or Abuse. The provider shall notify the Department in all documented cases of Misuse or Abuse within ten business days of learning of the incident of Misuse or Abuse.

8.590.4.N. Previously used or donated DME may be provided to the member if agreed upon by the member and the Department. Approval will be coordinated by the Utilization Management Vendor.

8.590.4.O. The Provider shall assure that used or donated items provided meet the following conditions:

1. The item is fully serviced and reconditioned.

2. The item is functionally sound and in good operating condition.

3. The item will be repaired and have parts replaced in a manner equivalent to an item that is new. The item will have parts available for future repairs in a manner equivalent to the manufacturer's warranty on a like item which is new.

4. The provider will make all adjustments and modifications needed by the member during the first year of use, except for changes and adjustments required due to growth or other anatomical changes or for repairs not covered by the manufacturer's warranty on a like new item.

8.590.4.P. The provider shall receive and perform service and repairs in the same manner they provide services for non-Medicaid clients for rental equipment.

8.590.4.Q. The provider shall assure the following for rental equipment:

1. Appropriate service to the item.

2. Complete services or repairs in a timely manner with an estimate of the approximate time required.

3. Appropriate alternative equipment during repairs.

4. Provision and replacement of all expendable items, including but not limited to hoses, fuses, and batteries.

**8.590.5 PROVIDER REQUIREMENTS**

8.590.5.A. Providers are required to be enrolled with the Colorado Medical Assistance Program and maintain a certification for Medicare accreditation through a Medicare approved accreditation agency.

8.590.5.B. Providers must have one or more physical location(s), within the State of Colorado, or within fifty (50) miles of any Colorado border and must also have:

1. A street address; and

2. A local business telephone number; and

3. An inventory; and

4. Sufficient staff to service or repair products.

8.590.5.C. Providers who do not meet the requirements of 8.590.5.A may apply to become a Medicaid provider if the DME or Supplies are medically necessary and cannot otherwise be purchased from a provider who meets the requirements of 8.590.5.A.

1. Applications from providers who do not meet the requirements of 8.590.5.A must be submitted to the DME Program Coordinator for approval.

2. Applications submitted pursuant to this section will be reviewed for approval on a case-by-case basis for those specialty items only.

8.590.5.D. To qualify as a Complex Rehabilitation Technology Supplier, a provider must meet the following requirements:

1. Be accredited by a recognized accrediting organization as a supplier of Complex Rehabilitation Technology;

2. Meet the supplier and quality standards established for DME suppliers under the Medicare or Medical Assistance Program;

3. Employ at least one Complex Rehabilitation Technology Professional at each physical location to:

   a. Analyze the needs and capacities of a member for a Complex Rehabilitation Technology item in consultation with the evaluating clinical professionals;

   b. Assess and determine the appropriate Complex Rehabilitation Technology for a member, with such involvement to include seeing the member either in person or by any other real-time means within a reasonable time frame during the determination process; and

   c. Provide the member with technology-related training in the proper use and maintenance of the selected Complex Rehabilitation Technology items.

4. Maintain a reasonable supply of parts, adequate physical facilities, qualified and adequate service or repair technicians to provide members with prompt service and repair of all Complex Rehabilitation Technology it sells or supplies.

**8.590.6 MEMBER RESPONSIBILITIES**

8.590.6.A. Members or member caregivers shall be responsible for the prudent care and use of DME and Supplies. Repairs, servicing or replacement of items are not a benefit if there is documented evidence of member Misuse, Abuse or Wrongful Disposition.

8.590.6.B. Members shall be responsible for the cost of any additional items or enhancements to equipment not deemed Medically Necessary. The member shall sign an agreement with the provider that states:

1. The cost of the items.

2. That the member was not coerced into purchasing the items.

3. That the member is fully responsible for the cost, servicing and repairs to the items after the warranty period is completed.

8.590.6.C. The member shall contact the point of purchase for service and repairs to covered items under warranty. Members may contact a participating provider of their choice for service and repairs to covered items not under warranty or for an item under warranty if the original point of purchase is no longer a participating provider.

8.590.6.D. The member shall become the owner of any equipment purchased by the Department and remains subject to Medicaid DME rules unless otherwise notified by the Department at the time of purchase.

8.590.6.E. The member shall be responsible for obtaining a police report for items being replaced due to theft, fire damage or accident. The police report shall be attached to the prior authorization requesting replacement of the item.

8.590.6.F. The member shall be responsible for reporting to the manufacturer, dealer or alternative warranty service provider instances where a Wheelchair or Facilitative Device does not conform to the applicable express warranty.

8.590.6.G. The member or caregiver shall be responsible for routine maintenance on all equipment purchased or rented by the Department. Routine maintenance is the servicing described in the manufacturer's operating manual as being performed by the user to properly maintain the equipment. Non-performance of routine maintenance shall be considered Misuse. Routine maintenance includes, but is not limited to:

1. Cleaning and lubricating moving parts.

2. Adding water to batteries.

3. Checking tire pressure.

4. Other prescribed Manufacturer procedures.

8.590.6.H. The member utilizing rental equipment shall be responsible for notifying the provider of any change of address. The member shall be responsible for any rental fee accrued during the time the equipment's location is unknown to the provider.

8.590.6.I. The member shall not remove rental equipment from Colorado.

**8.590.7 REIMBURSEMENT**

8.590.7.A. A provider, as defined at Section 25.5-4-414, C.R.S., is prohibited from making a referral to an entity providing DME and Supplies under the Medical Assistance Program if the provider or an Immediate Family member of the provider has a Financial Relationship with the entity unless the Financial Relationship meets the requirements of an exception to the prohibitions established by 42 U.S.C. Section 1395nn (2017), as amended or any regulations promulgated thereunder, as amended. 42 U.S.C. §1395nn (2017) is hereby incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado.

8.590.7.B. If a provider refers a Medicaid member for DME and Supplies services in violation of Section 25.5-4-414, C.R.S., or this rule, then the Department may

1. Deny any claims for payment from the provider;

2. Require the provider to refund payments for services or items;

3. Refer the matter to the appropriate agency for investigation for fraud; or

4. Terminate the provider's Colorado Medicaid provider participation agreement.

8.590.7.C. Invoices received from Related Owners or Related Parties shall not be accepted. Only invoices received from unrelated manufacturers or wholesale distributors shall be recognized as allowable invoices.

8.590.7.D. The provider shall not bill the Department for authorized accessory items included by the manufacturer as part of a standard package for an item.

8.590.7.E. The provider shall credit the cost of any accessory or part removed from a standard package to the Department.

8.590.7.F. Members and providers may negotiate in good faith a trade-in amount for DME items no longer suitable for a member because of growth, development or a change in anatomical and or medical condition. Such trade-in allowances shall be used to reduce the cost incurred by the Department for a replacement item.

8.590.7.G. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacturer; wherever the item was returned, and the Department.

8.590.7.H. Reimbursement for allowable modifications, service, and repairs on DME is as follows:

1. Labor for modifications, service, and repairs on DME shall be reimbursed at the lesser of submitted charges or the rate specified on the Department's fee schedule.

2. Parts that are listed on the Department's fee schedule, with a HCPCS code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

3. Manually priced parts are reimbursed according to the same methodology used for purchased equipment, as described in 8.590.7.K.

4. The provider shall not be reimbursed for labor or parts in excess of unit limitations.

5. Reimbursement for a modification that requires the original equipment provider to supply a part from their own inventory or stock is contingent upon the provider submitting supporting documentation that demonstrates the need and actual cost of the parts to be used in the modification.

8.590.7.I. Reimbursement for used equipment shall include:

1. A written, signed and dated agreement from the member accepting the equipment.

2. Billing the Department, the lesser of 60% of the maximum allowable reimbursement indicated in the most recent Medicaid Bulletin or 60% of the provider's usual submitted charges.

a. For used equipment subject to the upper payment limit provisions of section 1903(i)(27) of the Social Security Act, the maximum allowable reimbursement will be the lower of 100% of the applicable Medicare used reimbursement rate effective as of January 1 and posted by July 1 of each year, or the provider's submitted charges.

8.590.7.J. Reimbursement for purchased or rented equipment shall include, but is not limited to:

1. All elements of the manufacturer's warranties or express warranties.

2. All adjustments and modification needed by the member to make the item useful and functional.

3. If item is delivered, set-up and installation of equipment in an appropriate room in the home, if applicable.

4. Training and instruction to the member or caregiver in the safe, sanitary, effective and appropriate use of the item and necessary servicing and maintenance to be done by the member or caregiver.

5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides.

8.590.7.K. Reimbursement rate for a purchased item shall be as follows:

1. Fee schedule items, with a HCPCS code, that have a maximum allowable reimbursement rate, shall be reimbursed at the lesser of submitted charges or the Department fee schedule rate.

2. Manually priced items that do not have an assigned fee schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less a percentage set forth below:

a. July 1, 2018 to June 30, 2019, the percentage is 17.51.

b. Pending federal approval, effective July 1, 2019, the percentage is16.69.

3. Manually priced items that do not have an assigned fee schedule rate and have no MSRP shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus a percentage set forth below:

    c. July 1, 2018 to June 30, 2019, the percentage is 20.70.

    d. Pending federal approval, effective July 1, 2019, the percentage is21.90.

8.590.7.L. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Billing Manual.

8.590.7.M. Reimbursement for members eligible for both Medicare and Medicaid shall be made in the following manner:

1. The provider shall bill Medicare first unless otherwise authorized by the Department.

2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments.

3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions:

    a. A copy of the Explanation of Medicare Benefits shall be maintained in the provider's files when billing electronically or attached to the claim if it is billed manually; or

    b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error.

8.590.7.N. Face-to-Face Encounters

1. For DME specified in the Billing Manual, a face-to-face encounter must be performed related to the primary reason a member requires the DME.

2. The face-to-face encounter must occur no more than six months before the DME is first provided to a member.

3. The face-to-face encounter must be conducted by one of the following practitioners:

    a. The physician responsible for prescribing the DME;

    b. A nurse practitioner or clinical nurse specialist, working in collaboration with the prescribing physician; or

    c. A physician assistant under the supervision of the prescribing physician.

4. A practitioner may conduct a face-to-face encounter via telehealth or telemedicine if those services are covered by the Medical Assistance Program.

5. If a non-physician practitioner performs a face-to-face encounter they must communicate the clinical findings of the face-to-face encounter to the physician responsible for prescribing the related DME. Those clinical findings must be incorporated into a written or electronic document included in the member's medical record.

6. A physician who prescribes DME requiring face-to-face encounters must document the following:

   a. The face-to-face encounter was related to the primary reason the member required the prescribed DME;

   b. The practitioner who performed the face-to-face encounter;

   c. The date of the face-to-face encounter; and

   d. The face-to-face encounter occurred within the required timeframe.

7. Compliance with this section is required as a condition of payment for DME requiring face-to-face encounters.

8.590.7.O. Reimbursement for Complex Rehabilitation Technology provided to members is subject to the following conditions:

1. The billing provider is a Complex Rehabilitation Technology Supplier;

2. The member has been evaluated or assessed, for selected Complex Rehabilitation Technology identified in the Billing Manual, by:

   a. A Qualified Health Care Professional; and

   b. A Complex Rehabilitation Technology Professional employed by the billing provider.

3. The Complex Rehabilitation Technology is provided in compliance with all applicable federal and state laws, rules, and regulations, including those rules governing the Medical Assistance Program.

8.590.7.P. Reimbursement for Speech Generating Devices (SGD), accessories, and software provided to members is subject to the following conditions:

1. The member has a medical condition resulting in a severe expressive communication impairment; and

2. The SGD, accessories and software is used primarily as a communication device; and

3. The SGD, accessories or software are recommended by a Speech Language Pathologist after a communication assessment as described at 10 CCR 2505-10, Section 8.590.3.E.1; and

   a. The recommended device, software or application should be capable of modifications to meet the needs for supportive functional communication when possible. The recommended software or application must be compatible with the prescribed SGD.

   b. Accessories and supplies that do not have a primary medical use will not be covered, which includes any items that are unnecessary for operation of the SGD, or are unrelated to the SGD.

      i. Covered accessories include but are not limited to:

1. Replacement lithium ion batteries;

2. Non-electric SGD communication board;

3. Mounting systems designated for securing the SGD within reach of the client;

4. Safety and protection accessories designated to maintain the life expectancy of the device,

5. Accessories not otherwise classified may be approved to enhance the use of the SGD system as the member's condition changes; and

6. Orthotic and prosthetic supplies and accessories, and/or service components of another HCPCS L code.

4. Other forms of treatment have been considered or ruled out; and

5. The member's communication impairment will benefit from the SGD, accessories, or software.

## 10 CCR 2505-10, SECTION 8.500-8.599, APPENDIX A: PEDIATRIC PERSONAL CARE SERVICES BENEFIT COVERAGE STANDARD

Capitalized terms within this Benefit Coverage Standard that do not refer to the title of a benefit, program, or organization, have the meaning specified in the Definitions section.

### A. BRIEF COVERAGE STATEMENT

This Benefit Coverage Standard describes Pediatric Personal Care (PC) Services benefits for Colorado Medicaid clients under 21 years of age. PC Services are Medically Necessary services provided to assist the client with PC Tasks in order to meet the client's physical, maintenance, and supportive needs. This assistance may take the form of Hands-On Assistance, Supervision, or Cuing the client to complete the PC Task.

### B. RELATED SERVICES ADDRESSED IN OTHER BENEFIT COVERAGE STANDARDS

1. Home Health

2. Private Duty Nursing

### C. ELIGIBLE PROVIDERS

1. Ordering, Prescribing, Referring (OPR) Providers

   In accordance with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, all 485 Plans of Care—or other form with identical content—must be signed by one of the following:

   a. Physician

      i) Doctor of Medicine (MD), or

      ii) Doctor of Osteopathic Medicine (DO)

   b. Advanced Practice Nurse

2. Personal Care Workers

   As a condition of reimbursement, Personal Care Workers (PCW) must meet all of the following requirements:

   a. Not excluded from participation in any federally funded health care programs,

   b. Employed by or providing services under a contract with a licensed Class A or Class B Home Care Agency (HCA) that is enrolled as a Colorado Medicaid provider;

   c. Completion of the Department's PC Services provider training; and has verified experience in the provision of PC Services for clients, as regulated by the Colorado Department of Public Health and Environment (CDPHE) at 6 CCR 1011-1, Chapter 26, Section 8.5.

## D. AGENCY REQUIREMENTS

As a condition of reimbursement, Home Care Agencies (HCAs) must meet all of the following requirements:

1. Licensed by the State of Colorado as either a Class A or Class B Agency in good standing;

2. Maintain up-to-date personnel files for each PCW, containing proof of current training, education, and PCW competency, as appropriate to the client's needs and as required by CDPHE; and

3. Comply with the requirements outlined in the Personal Care Worker Supervision section of this Benefit Coverage Standard.

## E. ELIGIBLE PLACES OF SERVICE

Pediatric PC Services are covered under this benefit when provided in a client's Residence or outside a client's Residence, subject to the limitations listed in the Non-Covered Services section of this Benefit Coverage Standard.

## F. ELIGIBLE CLIENTS

Pediatric PC Services are a benefit for Colorado Medicaid clients who:

1. Are 20 years of age or younger; and

2. Qualify for moderate to total assistance with at least one Personal Care Task

## G. GENERAL REQUIREMENTS

For Medicaid clients ages 20 and younger, Pediatric PC Services are covered in accordance with the provisions of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program found at 10 CCR 2505-10 Section 8.280.

1. Requirements of Covered Services

   Pediatric PC Services are covered only when:

   a. Medically Necessary, as defined in Colorado Medicaid's EPSDT rule at 10 C.C.R. 2505-10, Section 8.280;

   b. Provided to assist the client with PC Tasks, in order to meet the client's physical, maintenance, and supportive needs;

   c. Provided on an intermittent basis;

   d. Provided for the sole benefit of the client;

   e. Prior authorized and delivered in a manner consistent with professional standards, Colorado licensure requirements, and all other applicable state and federal regulations;

   f. Ordered by a licensed physician, as regulated by the Department of Regulatory Agencies (DORA), or an advanced practice nurse, as licensed by DORA; and

g. Provided under a current, written 485 Plan of Care, signed by the Ordering Provider.

2. Documentation Requirements

The HCA is required to maintain a record for each client. The record for each client must include all of the following:

a. A 485 Plan of Care completed by the Ordering Provider. This constitutes a written order for PC services. The 485 Plan of Care must be updated at least annually, or more frequently if required by the needs or condition of the individual client, and must include:

i) The frequency of each PC Task required by the client.

ii) A range of the frequency for each PC Task required by the client on an as-needed basis. An order for a PC Task "PRN" or "as needed" must be accompanied by a range of the frequency with which the client may require that PC Task to be provided.

iii) Documentation or explanation for each PC Task that is required more frequently than the defined Usual Frequency for that task.

b. Evidence of Care Coordination between the HCAs, when the client is receiving other services from another agency, including but not limited to Medicaid Home Health services, Medicaid HCBS waiver programs, and services from other payers.

c. Documentation of consultations with relevant medical staff when clients have complex needs or when there are potentially dangerous situations identified.

d. A written explanation of how the requested PC Services do not overlap with any other services the client is receiving from another agency.

e. All other client file information, as required by Colorado Medicaid, and by CDPHE, as outlined in rule at 6 C.C.R. 1011-1, Chapter 26, Section 6.20.

## H. COVERED SERVICES

Under the description of each task below, Usual Frequency of Task refers to the number of times a typical client is likely to need a task performed. A PC Task will be performed at the usual frequency, unless otherwise specified on the 485 Plan of Care. If a client needs a PC Task performed more frequently than the usual frequency for that PC Task, it must be specified on the 485 Plan of Care.

Covered Pediatric PC Services include assistance with the following PC Tasks:

1. Bathing/Showering

   a. Included in Task:

      Bathing/shower includes: Preparing bathing supplies and equipment, assessing the water temperature, applying soap (including shampoo), rinsing off, and drying the client; cleaning up after the bath, shower, bed bath, or sponge bath as needed; all transfers and ambulation related to the bathing/showering task; and all hair care, pericare, and skin care provided in conjunction with the bathing/showering task.

   b. Usual Frequency of Task: Once daily.

   c. Factors that Make Task Personal Care:

      Client is able to maintain balance and bear weight reliably, or able to use safety equipment (such as a shower bench) to safely complete the bathing/showering; client's skin is unbroken; client is independent with assistive devices; or when a PCW is assisting a medically-skilled care provider, caregiver, or Unpaid Family Caregiver who is competent in providing this aspect of care.

   d. Factors that Make Task Skilled:

      There is the presence of open wound(s), stoma(s), broken skin and/or active chronic skin disorder(s); or client is unable to maintain balance or to bear weight reliably due to illness, injury, or disability, history of falls, or a temporary lack of mobility due to surgery or other exacerbation of illness, injury, or disability.

   e. Special Considerations:

      A second person may be staffed when required to safely bathe the client, when supported by documentation that illustrates that the client requires moderate to total assistance to safely complete this task.

2. Dressing

   a. Included in Task:

      Dressing includes putting on and taking off clothing, including pantyhose or socks and shoes. Dressing includes getting clothing out and may include braces and splints if purchased over the counter and/or or not ordered by a Qualified Physician.

   b. Usual Frequency of Task: Up to two times daily.

c. Factors that Make Task Personal Care:

Client only needs assistance with ordinary clothing and application of support stockings of the type that can be purchased without a physician's prescription; when assistance is needed with transfers and positioning related to dressing and undressing, which may include the cleaning and maintenance of braces, prosthesis, or other DME; or when a PCW is assisting a skilled care provider, caregiver, or Unpaid Family Caregiver who is competent in providing the application of an ace bandage and anti-embolic or pressure stockings or placement of braces or splints that can be obtained only with a prescription of a Qualified Physician, or when the client is unable to assist or direct care.

d. Factors that Make Task Skilled:

Client requires assistance with the application of anti-embolic or pressure stockings, placement of braces or splints that can be obtained only with a prescription of a Qualified Physician, or when the client is unable to assist or direct care. Services may also be skilled when the client experiences a temporary lack of mobility due to surgery or other exacerbation of illness, injury, or disability.

e. Special Considerations:

A PCW may be staffed with a skilled care provider or Unpaid Family Caregiver when required to safely dress the client, and when supported by documentation that illustrates that the client requires moderate to total assistance to safely complete this task.

3. Feeding

a. Included in Task:

Feeding includes ensuring food is the proper temperature, cutting food into bite-size pieces, or ensuring the food is at the proper consistency for the client, up to and including placing food in client's mouth.

b. Usual Frequency of Task: Up to three times daily.

c. Factors that Make Task Personal Care:

The client can independently chew and swallow without difficulty and be positioned upright; the client is able to eat or be fed with adaptive utensils.

d. Factors that Make Task Skilled:

The client requires syringe feeding and tube feeding, which may be performed by a CNA who has been deemed competent to administer feedings via tube or syringe;

Oral feeding when: The client is unable to communicate verbally, non-verbally, or through other means; the client is unable to be positioned upright; the client is on a modified texture diet; the client has a physiological or neurogenic chewing and/or swallowing problem; or when a structural issue (such as cleft palate), or other documented swallowing issue exists.

The client has a history of aspirating food or is on mechanical ventilations that may create a skilled need for feeding assistance, or; when oral suctioning is required.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task. If a client requires snacks in addition to three meals per day, this need must be specified in the 485 Plan of Care.

4. Medication Reminders

a. Included in Task:

Medication Reminders include verbally communicating to a client that it is time for medication, and/or opening and handing a pre-filled medication reminder container to a client.

b. Factors that Make Task Personal Care:

PCWs may assist clients with medication reminders by: inquiring whether medications were taken; verbally prompting the client to take medications; handing the appropriately marked medication reminder container to the client; and opening the appropriately marked medication reminder container for the client if the client is physically unable to open the container.

All medication (prescription medications and all over-the-counter medications) must be pre-selected by the client, the client's Unpaid Family Caregiver, a nurse, CNA, or a pharmacist, and stored in pre-filled medication reminder boxes which are marked with day and time of dosage.

c. Factors that Make Task Skilled:

Medication reminders are PCW tasks unless the client requires services within the scope of a certified CNA.

5. Ambulation/Locomotion

a. Included in Task:

Walking or moving from place to place with or without an assistive device (including wheelchair).

b. Factors that Make Task Personal Care:

A PCW may assist clients with ambulation only if the client has the ability to balance and bear weight reliably, when the client is independent with an assistive device, or when the PCW is assisting a skilled care provider or Unpaid Family Caregiver who is competent in providing the skilled aspect of care.

c. Factors that Make Task Skilled:

Ambulation is considered a skilled task when the client: is unable to assist in the task, direct care, or when hands-on assistance is required for safe ambulation.

The task is also considered skilled when a client is unable to maintain balance, unable to bear weight reliably, or has not been deemed independent with assistive devices ordered by a Qualified Physician.

d. Special Considerations:

Ambulation may not be the standalone reason for a visit. Transferring and positioning into and out of assistive devices is not ambulation, and is addressed in the transferring and positioning section of this standard. Documentation must illustrate the need for moderate to total assistance to safely complete this task.

6. Meal Preparation

a. Included in Task:

Meal preparation includes preparing, cooking, and serving food to a client. Includes formula preparation and ensuring food is a proper consistency based on the client's ability to swallow safely.

b. Usual Frequency of Task: Up to three times daily.

c. Factors that Make Task Personal Care:

All meal preparation is a PC task, except as defined in the Factors that Make Task Skilled portion of this section.

d. Factors that Make Task Skilled:

Meal preparation is considered a skilled task when the client's diet requires nurse oversight to administer correctly. Meals must have a modified consistency.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

7. Hygiene – Hair Care/Grooming

a. Included in Task:

Hair care includes shampooing, conditioning, drying, styling, and combing; it does not include perming, hair coloring, or other styling.

b. Usual Frequency of Task: Up to twice daily.

c. Factors that Make Task Personal Care:

PCWs may assist clients with the maintenance and appearance of their hair. Hair care within these limitations includes: shampooing with non-medicated shampoo or medicated shampoo that does not require a physician's prescription; and drying, combing, and styling of hair.

d. Factors that Make Task Skilled:

Hair care is considered a skilled task when the client requires shampoo or conditioner that is prescribed by a qualified physician and dispensed by a pharmacy; or when the client has one or more open wounds or stomas on the head.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task. Active and chronic skin issues such as dandruff and cradle cap do not make this task skilled.

8. Hygiene – Mouth Care

a. Included in Task:

Mouth care includes brushing teeth, flossing, use of mouthwash, denture care, or swabbing with a toothette.

b. Usual Frequency of Task: Up to three times daily.

c. Factors that Make Task Personal Care:

A PCW may assist and perform mouth care, including denture care and basic oral hygiene.

d. Factors that Make Task Skilled:

Mouth care is considered a skilled task when the client: is unconscious; has difficulty swallowing; is at risk for choking and aspiration; has decreased oral sensitivity or hypersensitivity; has an injury or medical disease of the mouth; is on medications that increase the risk of dental problems, bleeding, injury, or disease of the mouth; or requires oral suctioning.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task. The presence of gingivitis, receding gums, cavities, or other general dental problems does not make mouth care skilled.

9. Hygiene - Nail Care

a. Included in Task:

Nail care includes soaking, filing, and cuticle care.

b. Usual Frequency of Task: Up to one time weekly.

c. Factors that Make Task Personal Care:

A PCW may assist with nail care, which includes soaking of nails, pushing back cuticles with or without utensils, and filing of nails. A PCW may not assist with nail trimming.

d. Factors that Make Task Skilled:

Nail care is considered a skilled task when the client: has a medical condition that involves peripheral circulatory problems or loss of sensation; is at risk for bleeding or is at a high risk for injury secondary to the nail care; or requires nail trimming.

Skilled nail care may only be completed by a CNA who has been deemed competent in nail care for this population.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

10. Hygiene – Shaving

a. Included in Task:

Shaving includes assistance with shaving of face, legs, and underarms with a safety or electric razor.

b. Usual Frequency of Task: Up to one time daily. Task may be completed with bathing or showering.

c. Factors that Make Task Personal Care:

A PCW may assist a client with shaving with an electric or a safety razor.

d. Factors that Make Task Skilled:

Shaving is considered a skilled task when the client: has a medical condition that involves peripheral circulatory problems or loss of sensation; has an illness or takes medications that are associated with a high risk for bleeding; has broken skin at or near shaving site; has a chronic active skin condition; or is unable to shave him or herself.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

11. Hygiene – Skin Care

a. Included in Task:

Skin care includes applying lotion or other skin care products, only when not completed in conjunction with bathing or toileting (bladder or bowel). May be provided in conjunction with positioning.

b. Factors that Make Task Personal Care:

A PCW may provide general skin care assistance only when a client’s skin is unbroken and when no chronic skin problems are active.

The skin care provided by a PCW must be preventive, rather than therapeutic, in nature. It includes the application of skin care lotions and solutions not requiring a physician's prescription.

c. Factors that Make Task Skilled:

Skin care is considered a skilled task when the client: requires skin care lotions or solutions requiring a physician's prescription; has broken skin, wound(s), or an active chronic skin problem; or is unable to apply product independently due to illness, injury, or disability.

d. Special Considerations:

Skin care completed in conjunction with bathing and toileting, as ordered on the 485 Plan of Care, is not included in this task. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

12. Toileting – Bowel Care

a. Included in Task:

Bowel Care includes changing and cleaning an incontinent client, or providing hands-on assistance with toileting. This includes returning the client to pre-bowel movement status, transfers, skin care, ambulation, and positioning related to elimination.

b. Factors that Make Task Personal Care:

A PCW may assist a client to and from the bathroom; provide assistance with bedpans and commodes; provide pericare; or change clothing and pads of any kind used for the care of incontinence.

A PCW may assist a skilled care provider or Unpaid Family Caregiver who is competent in providing this aspect of care.

c. Factors that Make Task Skilled:

Bowel Care is considered a skilled task when: the client is unable to assist or direct care; has broken skin or recently healed skin breakdown (less than 60 days); requires skilled skin care associated with bowel care; or has been assessed as having a high and ongoing risk for skin breakdown.

d. Special Considerations:

A PCW may be aided by a skilled care provider or Unpaid Family Caregiver when required to safely complete Bowel Care with the client. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

13. Toileting – Bowel Program

    a. Included in Task:

    Bowel Program includes emptying the ostomy bag, as ordered by the client's Ordering Provider. This includes skin care at the site of the ostomy and returning the client to pre-bowel program status.

    b. Factors that Make Task Personal Care:

    A PCW may empty ostomy bags and provide client-directed assistance with other ostomy care only when there is no need for skilled bowel program care, for skilled skin care, or for observation or reporting to a nurse.

    A PCW may not perform digital stimulation, insert suppositories, or give an enema.

    c. Factors that Make Task Skilled:

    Bowel Program is considered a skilled task when: the client requires the use of digital stimulation, suppositories, or enemas; or when the client requires skilled skin care at the ostomy site.

    d. Special Considerations:

    Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

14. Toileting – Catheter Care

    a. Included in Task:

    Catheter Care includes perineal care and emptying catheter bags. This includes transfers, skin care, ambulation, and positioning related to catheter care.

    b. Usual Frequency of Task: Up to two times a day.

    c. Factors that Make Task Personal Care:

    A PCW may empty urinary collection devices such as catheter bags when there is no need for observation or reporting to a nurse; and provide pericare for clients with indwelling catheters.

    d. Factors that Make Task Skilled:

    Catheter Care is considered a skilled task when: emptying indwelling or external urinary collection devices and there is a need to record and report the client’s urinary output to the client’s nurse; task involves insertion, removal, and care of all catheters; changing from a leg to a bed bag and cleaning of tubing and base; or if the indwelling catheter tubing needs to be opened for any reason and the client is unable to do so independently.

e. Special Considerations:

Catheter Care may not be the sole purpose of the visit. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

15. Toileting – Bladder Care

a. Included in Task:

Bladder Care includes assistance with toilet, bedpan, urinal, or diaper use, as well as emptying and rinsing the commode or bedpan after each use. This includes transfers, skin care, ambulation, and positioning related to bladder care. This task concludes when the client is returned to his or her pre-urination state.

b. Factors that Make Task Personal Care:

A PCW may assist a client to and from the bathroom, provide assistance with bedpans, urinals, and commodes; provide pericare; and change clothing and pads of any kind used for the care of incontinence.

c. Factors that Make Task Skilled:

Bladder care is considered a skilled task when the client: is unable to assist or direct care; has broken skin or recently healed skin breakdown (less than 60 days); requires skilled skin care associated with bladder care; or has been assessed as having a high and ongoing risk for skin breakdown.

d. Special Considerations:

A PCW may assist a skilled care provider or Unpaid Family Caregiver who is competent in providing this aspect of care. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

16. Mobility – Positioning

a. Included in Task:

Positioning includes moving the client from a starting position to a new position while maintaining proper body alignment and support to a client's extremities, and avoiding skin breakdown.

b. Factors that Make Task Personal Care:

A PCW may assist a client with positioning when the client is able to identify to the provider, verbally, non-verbally, or through other means including but not limited to, a legally responsible adult or adaptive technologies, when his or her position needs to be changed, and only when skilled skin care is not required in conjunction with positioning. Positioning includes alignment in a bed, wheelchair, or other furniture; and the placement of padding required to maintain proper alignment. The PCW may receive direction from or assist a skilled care provider or Unpaid Family Caregiver who is competent in providing this aspect of care.

c. Factors that Make Task Skilled:

Positioning is considered a skilled task when the client is: unable to communicate verbally, non-verbally, or through other means; or unable to perform this task independently due to illness, injury, disability, or temporary lack of mobility due to surgery. Positioning includes adjusting the client's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a Qualified Physician.

d. Special Considerations:

Positioning and padding may not be the sole purpose for the PC visit. Positioning is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care, or other PC Tasks that require positioning.

If PC positioning is required for the completion of a skilled care task, visits must be coordinated to effectively schedule these services. A PCW may be accompanied by a skilled care provider or Unpaid Family Caregiver when required to safely position the client. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

17. Mobility - Transfer

a. Included in Task:

Transfers include moving the client from a starting location to a different location in a safe manner. It is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care, or other PC Task.

b. Factors that Make Task Personal Care:

A PCW may assist with transfers only when the client has sufficient balance and strength to reliably stand, pivot, and assist with the transfer to some extent. Adaptive equipment, including, but not limited to, wheelchairs, tub seats, and grab bars, and safety devices may be used in transfers if: the client and PCW are fully trained in the use of the equipment; the client, or client's Unpaid Family Caregiver, can direct the transfer step-by-step; or when the PCW is deemed competent by the employer HCA in the specific transfer technique for the client. A gait belt may be used in a transfer as a safety device if the PCW has been properly trained in its use. A lift is not an included safety device and may not be used in PC transfers.

c. Factors that Make Task Skilled:

Transfers are considered a skilled task when the client: is unable to communicate verbally, non-verbally, or through other means; is not able to perform this task independently due to illness, injury, disability, or temporary lack of mobility due to surgery; lacks the strength and stability to stand or bear weight reliably; is not deemed independent in the use of assistive devices or Durable Medical Equipment that has been ordered by a Qualified Physician; or when the client requires a mechanical lift, such as a Hoyer lift, for safe transfer. In order to transfer clients via a mechanical lift, the CNA must be deemed competent in the particular mechanical lift used by the client.

d. Special Considerations:

Transfers may be completed with or without mechanical assistance. Transferring shall not be the sole purpose for the visit. A transfer is not considered a separate task when performed in conjunction with bathing, bladder care, bowel care, or other PC Task. A PCW may be aided by a skilled care provider or Unpaid Family Caregiver when required to safely transfer the client. A PCW may assist the Unpaid Family Caregiver with transferring the client, provided the client is able to direct and assist with the transfer. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

## I. LIMITATIONS

1. Medicaid clients ages 21 and older are not eligible for Pediatric PC Services.

2. The use of physical Behavioral Interventions such as restraints is prohibited, per CDPHE's consumer rights regulations. 6 C.C.R. 1011-1, Chapter 26, Section 6.

3. All PCWs and HCAs must comply with all applicable Colorado and federal requirements, rules, and regulations.

4. All Pediatric PC Services will be reimbursed at the Medicaid Pediatric PC Services rate, regardless of whether the PCW providing PC Services holds credentials for CNA, RN, or other skilled profession.

5. If a client requires a Skilled Transfer to complete a PC Task, the associated PC Task will be considered skilled in nature. PC Tasks considered skilled in nature are not covered PC Services, and will not be reimbursed by Colorado Medicaid under the Pediatric PC Services benefit.

6. PC Tasks provided as required components of skilled care tasks are not covered PC Services, and will not be reimbursed by Colorado Medicaid under the Pediatric PC Services benefit.

7. Clients eligible for the Pediatric PC Services benefit who are also eligible for the Colorado Department of Human Services Home Care Allowance program, described in rule at 9 C.C.R. 2503-5, Section 3.570, may receive services through one program, but not both.

8. If a PC Task is provided to a client by a PCW and a Skilled Care worker, but only one staff person is required, the PCW will not be reimbursed by Colorado Medicaid under the Pediatric PC Services benefit.

9. If a PC Task is provided to a client by two PCWs from different HCAs, but only one PCW is required, Colorado Medicaid will reimburse solely the HCA with a history of providing that particular PC Task to the client.

10. Two staff may be reimbursed for the same PC service for a client only when two people are required to safely provide the service, two staff were approved by prior authorization for the service, and there is no other person available to assist in providing this service.

11. HCAs may decline to perform a specific task or service, regardless of whether the task is a covered Pediatric PC Service, if the supervisor or the PCW documents a concern regarding the safety of the client or the PCW.

## J. PERSONAL CARE WORKER SUPERVISION

1. PCWs must periodically receive onsite supervision by a Registered Nurse, the clinical director, home care manager, or other home care employee who is in a designated supervisory capacity and is available to the PCW at all times. This onsite supervisory visit must occur at least every 90 days, or more often as necessary for problem resolution, skills validation of the PCW, client-specific or procedure-specific training of the PCW, observation of client's condition and care, and assessment of client's satisfaction with services. At least one of the assigned PCWs must be present at the onsite supervisory visit.

2. Each PCW must have a complete and up-to-date personnel file that demonstrates that the PCW has:

    a. Signed and dated evidence that he/she has received training and orientation on the HCA's written policies and procedures;

    b. Signed and dated evidence that he/she has received training and is competent to provide the client's specific PC Tasks;

    c. A signed and dated job description that clearly delineates his/her responsibilities and job duties;

    d. Proof that he/she is current and up to date on all training and education required by CDPHE at 6 C.C.R. 1011-1 Chapter 26, Section 8.6;

    e. Signed and dated competency information regarding training and skills validation for client-specific personal care and homemaking tasks;

    f. Signed and dated evidence that he/she has been instructed in basic first aid, and training in infection control techniques, including universal precautions;

    g. Information on any complaints received regarding the PCW, and documentation on the outcome and follow-up of the complaint investigation.

## K. PRIOR AUTHORIZATION REQUEST (PAR) REQUIREMENTS

1. Approval of the PAR does not guarantee payment by Medicaid. The presence of an approved or partially approved PAR does not release the HCA from the requirement to bill Medicare or other third party insurance prior to billing Medicaid.

2. All Pediatric PC Services require prior authorization by Colorado Medicaid or its Designated Review Entity using the approved utilization management tool.

3. Pediatric PC Services PARs may be submitted for up to a full year of anticipated services unless: the client is not expected to need a full year of services; the client's eligibility is not expected to span the entire year; or as otherwise specified by Colorado Medicaid or its Designated Review Entity.

4. A PAR will be pended by Colorado Medicaid or its Designated Review Entity if all of the required information is not provided in the PAR, or additional information is required by the Designated Review Entity to complete the review.

5. PARs must be submitted to Colorado Medicaid or its Designated Review Entity in accordance with 10 CCR 2505-10 § 8.058.

6. It is the HCA's responsibility to provide sufficient documentation to support the medical necessity for the requested services.

7. When a PAR includes a request for reimbursement for two staff members at the same time (excluding supervisory visits) to perform two-person transfers or another PC Task, documentation supporting the need for two people and the reason adaptive equipment cannot be used must be included.

8. All other information determined necessary by Colorado Medicaid or its Designated Review Entity to review a request and the appropriateness of the proposed treatment plan must be provided.

## L. NON-COVERED SERVICES

The following services are not covered under the Pediatric PC Services benefit:

1. Services that are not prior authorized by the Colorado Medicaid Designated Review Entity;

2. In accordance with Section 1905(a) of the Social Security Act, any services provided by the client's parents, foster parents, legal guardians, spouses, and other persons legally responsible for the well-being of the client;

3. Services provided by an individual under 18 years of age;

4. Services provided by a person not employed by the HCA;

5. Services provided through an Individual Residential Services and Supports (IRSS) or Group Residential Services and Supports (GRSS) program; or in any Medicaid-reimbursed setting, including, but not limited to medical offices, hospitals, hospital nursing facilities, alternative care facilities, and Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID).

6. PC Services that are covered under the client's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP);

7. Tasks that are defined as Skilled Care Services in the Home Health Services Rule at 10 CCR 2505-10 § 8.520;

8. Homemaker services, or tasks that are performed to maintain a household. These tasks are considered to be non-medical tasks and include grocery shopping, laundry, and housekeeping;

9. Exercise and range of motion services;

10. Protective Oversight services.

11. Services provided for the purpose of companionship, respite, financial management, child care, education, or home schooling; for the benefit of someone other than the Medicaid client; that are not justified by the documentation provided by the client's medical or functional condition (even when services have been prior authorized); or that are not appropriate for the client's needs;

12. Visits that occur for the sole purpose of supervising or training the PCW;

13. Any services that are reimbursable by another insurance agency or other state, federal, or private program;

14. PC Services provided during a Skilled Care Services visit;

15. Services provided by the client's Unpaid Family Caregiver; or

16. Assistance with services that are being provided as a reasonable accommodation as part of the Americans with Disabilities Act (ADA), the Rehabilitation Act of 1973, or Part B of the Individuals with Disabilities Education Act (IDEA).

**M. DEFINITIONS**

The following definitions are applicable only within the scope of this Benefit Coverage Standard.

**485 Plan of Care.** Refers to a CMS-485 Home Health Certification and Plan of Care, or a form that is identical in content. A 485 Plan of Care is a coordinated plan developed by the Home Care Agency as ordered by the Ordering Provider for provision of services to a client, and periodically reviewed and signed by the physician in accordance with Medicare requirements.

**Behavioral Intervention.** Techniques, therapies, and methods used to modify or minimize verbally or physically aggressive, combative, destructive, disruptive, repetitious, resistive, self-injurious, sexual, or otherwise inappropriate behaviors outlined on the 485 Plan of Care. Behavioral Interventions exclude frequent verbal redirection or additional time to transition or complete a task, which are part of the general service to the client's needs.

**Care Coordination.** The planned organization of client care tasks between two or more participants (including the client) involved in a client's care to facilitate the appropriate delivery of health care and other health care support services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required client care tasks, and is managed by the exchange of information among participants responsible for different aspects of care with the understanding that this information is or will be incorporated into the current or future medical care of the client.

**Centers for Medicare and Medicaid Services (CMS).** The federal government agency that works with states to run the Medicaid program. CMS is also responsible for the Medicare program.

**Certified Nurse Aide (CNA).** An employee of a Home Health Agency with a CNA certification. A CNA must have a current, active Colorado CNA certification and be employed by a Class A Home Health Agency. The CNA must have completed all required continuing education and training and have verified experience in the provision of Skilled Care Services.

**Class A Agency**. A Home Care Agency that provides any Skilled Care Service. Class A Agencies may also provide Personal Care Services.

**Class B Agency.** A Home Care Agency that provides only Personal Care Services. Class B Agencies may not provide any Skilled Care Services.

**Colorado Medicaid.** Colorado Medicaid is a free or low-cost public health insurance program that provides health care coverage to low-income individuals, families, children, pregnant women, seniors, and people with disabilities. Colorado Medicaid is funded jointly by the federal and state government, and is administered by the Colorado Department of Health Care Policy and Financing.

**Cuing**. Providing a prompt or direction to assist a client in performing PC Tasks he/she is physically capable of performing but unable to independently initiate.

**Designated Review Entity.** An entity that has been contracted by the Department to review Prior Authorization Requests (PARs) for medical necessity and appropriateness.

**Exacerbation.** A sudden or progressive increase in severity of a client's condition or symptoms related to a chronic illness, injury, or disability.

**Hands-On Assistance.** Performing a personal care task for a client.

**Home Care Agency (HCA)**. Refers collectively to Class A Agencies, which provide Home Health Services, and Class B agencies, which provide Personal Care Services. Home Care Agency is defined in full at 6 CCR 1011-1, Chap. 26 § 3.11. When used in this Benefit Coverage Standard without a Class A or Class B designation, the term encompasses both types of agency.

**Home Health Agency (HHA).** An agency that is licensed as a Class A Home Care Agency in Colorado that is Medicare certified to provide Skilled Care Services. Agencies must be actively enrolled as a Medicare and Medicaid Home Health provider in order to provide services to Medicaid clients. An agency that is licensed as a Class A Home Care Agency may also provide Personal Care Services based on the agency's policies and procedures.

**Home Health Services**.Services and care that, due to the inherent complexity of the service, can only be performed safely and correctly by a trained and licensed/certified nurse (RN or LPN), therapist (PT, OT, or SLP), or CNA.

**Homemaker Services**. General household activities provided in the Residence of an eligible client in order to maintain a healthy and safe home environment for the client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

**Intermittent Basis.** Personal Care Services visits that have a distinct start time and stop time and are task-oriented with the goal of meeting a client's specific needs for that visit.

**Medically Necessary**. Medical Necessity for Pediatric Personal Care Services is defined at 10 C.C.R. 2505-10, § 8.280.1.

**Ordering Provider**. A client's primary care physician, personal physician, advanced practice nurse, or other specialist who is responsible for writing orders and overseeing the client's 485 Plan of Care. This may include an alternate physician who is authorized by the Ordering Provider to care for the client in the Ordering Provider's absence.

**Personal Care Agency (PCA)**. A Class B Home Care Agency that is licensed by the Colorado Department of Public Health and Environment.

**Personal Care (PC) Services**. The provision of assistance, hands-on support with, or supervision of specific Personal Care Tasks to assist clients with activities of daily living.

**Personal Care (PC) Tasks**. Any of 17 daily living tasks described in the PC Benefit Coverage Standard.

**Personal Care Worker (PCW).** An employee of a licensed Home Care Agency who has completed the required training to provide Personal Care Services, or who has verified experience in the provision of Personal Care Services for clients, as regulated by the Colorado Department of Public Health and Environment at 6 C.C.R. 1011-1 Section 8.6. A client's Unpaid Family Caregiver cannot be a PCW for that client.

**Prior Authorization Request (PAR)**. A PAR is a request for determination that covered Medicaid services are medically necessary.

**Protective Oversight.** Monitoring a client to reduce or minimize the likelihood of injury or harm due to the nature of the client's injury, illness, or disability.

**Qualified Physician.** A primary care physician, personal physician, or other specialist who is currently licensed and in good standing.

**Rendering Provider.** The provider administering the service.

**Residence.** The physical structure in which the client lives. The Residence may be temporary or permanent. A Residence may be the client's own house, an apartment, a relative's home, or other temporary accommodation where the client resides. The Residence may not be a nursing facility or other institution, as defined by CMS and the State of Colorado.

**Skilled Care Services.** Services and care that, due to the inherent complexity of the service, can only be performed by a trained and licensed/certified nurse (RN or LPN), therapist (PT, OT or SLP), or CNA.

**Skilled Nursing Services.** Services provided by an actively licensed Registered Nurse, and services provided by a Licensed Practical Nurse under the direction of a Registered Nurse, in accordance with applicable state and federal laws, including but not limited to the Colorado Nurse Practice Act §§ 12-38-101 to -133, C.R.S., and 42 C.F.R 484.30.

**Skilled Transfer.** Supporting or enabling the movement of a client from place to place when the client does not have sufficient balance and strength to reliably stand and pivot and assist with the transfer to some extent. Adaptive and safety equipment may be used in transfers, provided that the skilled care worker is fully trained in the use of the equipment.

**State Plan.** An agreement between Colorado and the federal government describing how the Department administers its Medicaid program. The State Plan sets out groups of individuals to be covered, services to be provided, and the methodologies for providers to be reimbursed. It gives an assurance that the Department will abide by federal rules and may claim federal matching funds for its program activities.

**Supervision.** The act of ensuring that a client is performing a PC Task correctly and safely. Supervision may include actively intervening to ensure that a PC Task is completed without injury.

**Unpaid Family Caregiver.** A person who provides care to a client without reimbursement by the Department or other entity. Family members of a client will not be reimbursed by the Department for care provided to that client. Family members include, but are not limited to, parents, foster parents, legal guardians, spouses, and other persons legally responsible for the well-being of the client.

**Usual Frequency of Task**. The number of times a typical person is likely to need a task performed. A task will be performed at the Usual Frequency, unless otherwise specified on the 485 Plan of Care.

---

**Editor's Notes**

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 3/4/07, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 3/4/07, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

**History**

*[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]*