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.]

8.500.7 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.

8.500.18 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.

8.500.102 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, transition setup, individual job coaching, individual job development, job placement, workplace assistance, and benefits planning.

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 PCSP are based on the Client's identified needs as stated in the LOC Screen.

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

3. Provided to a Client are in accordance with the PCSP 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

8.500.108 CLIENT PAYMENT-POST ELIGIBILITY TREATMENT OF INCOME

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.505.1 DEFINITIONS

Definitions below only apply to Section 8.505.

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

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

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

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

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

8.505.2 REIMBURSEMENT RATE INCREASE

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

1. Group Residential Services and Supports;

2. Individual Residential Services and Supports;

3. Specialized Habilitation;

4. Respite;

5. Homemaker Basic;

6. Homemaker Enhanced;

7. Personal Care;

8. Prevocational Services;

9. Behavioral Line Staff;

10. Community Connector;

11. Supported Community Connections;

12. Mentorship;

13. Supported Employment- Job Development; And

14. Supported Employment- Job Coaching.

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

1. Executive Salaries

2. Administrative Expenses

3. Human Resource Expenses

4. Information Technology

5. Oversight Expenses

6. Business Management Expenses

7. General Record Keeping Expenses

8. Budget and Finance Expenses

9. Workers' Compensation Insurance

10. Contract Staffing Agency Expenses

11. Employee Appreciation Events

12. Gifts

13. Activities not identifiable to a single program.

8.505.3 REPORTING REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONAL RATE INCREASE

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

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

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

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

8.505.4 AUDITING REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONAL RATE INCREASE FOR COMPENSATION

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

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

1. Federal Employment Forms

   a. W2's -Wage and Tax Statement

   b. W3 -Transmittal of Wage and Tax Statement

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

   d. 940 -Employer's Annual Federal Tax Return

2. State Employment Forms

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

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

3. Business/Corporate Tax Returns

4. Independent Contractor Forms

   a. 1099's- Miscellaneous Income

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

5. Payroll Records

   a. Payroll Detail

   b. Payroll Summary

6. Accounting Records

   a. Chart of Accounts

   b. General Ledger

c. Profit & Loss Statements

d. Check Register

7. Bank Statements

8. Timesheets

9. Benefits Records

a. Health Insurance Records

b. Other Insurance Records

c. Paid Time Off Records

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

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

1. challenge the determination of the Department;

2. provide additional information to the Department demonstrating compliance;

3. submit a Plan of Correction to the Department.

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

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

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

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

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

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

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

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

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

2. is unable to provide documentation of compliance; or

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

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

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

8.507.1 DEFINITIONS

Definitions below only apply to Section 8.507.

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

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

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

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

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

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

8.507.2 REIMBURSEMENT RATE INCREASE

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

1. Homemaker Basic

2. Homemaker Enhanced

3. Personal Care

4. In-Home Support Services

    a. Exclusion: Health Maintenance Activities

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

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

1. Executive Salaries
2. Administrative Expenses
3. Human Resource Expenses
4. Information Technology
5. Oversight Expenses
6. Business Management Expenses
7. General Record Keeping Expenses
8. Budget and Finance Expenses
9. Workers' Compensation Insurance
10. Contract Staffing Agency Expenses
11. Employee Appreciation Events
12. Gifts
13. Activities not identifiable to a single program.

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

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

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

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

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

8.507.3 REPORTING REQUIREMENTS FOR DIRECT CARE WORKER RATE INCREASES

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

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

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

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

8.507.4 AUDITING REQUIREMENTS FOR DIRECT CARE WORKERS INCREASE FOR COMPENSATION

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

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

1. Federal Employment Forms

   a W2 - Wage and Tax Statement

   b. W3 - Transmittal of Wage and Tax Statement

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

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

2. State Employment Forms

   a. UITR 1 – State Unemployment Insurance Tax Report

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

3. Business/Corporate Tax Returns

4. Independent Contractor Forms

   a. 1099's- Miscellaneous Income

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

5. Payroll Records

a. Payroll Detail

b. Payroll Summary

6. Accounting Records

a. Chart of Accounts

b. General Ledger

c. Profit & Loss Statements

d. Check Register

7. Bank Statements

8. Timesheets

9. Benefits Records

a. Health Insurance Records

b. Other Insurance Records

c. Paid Time Off Records

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

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

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

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

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

1. Challenge the determination of the Department;

2. Provide additional information to the Department demonstrating compliance;

3. Submit a Plan of Correction to the Department.

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

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

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

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

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

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

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

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

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

2. is unable to provide documentation of compliance; or

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

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

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

8.508.103 MEDICATION ADMINISTRATION

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

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

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

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

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

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

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

8.508.110 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 Eligibility Determination and 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 LOC Screen 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.

8.509.17 POST-ELIGIBILITY TREATMENT OF INCOME (PETI)

A. Definition

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

B. Post Eligibility Treatment of Income Application

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

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

C. Case Management Responsibilities

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

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

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

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

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

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

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

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

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

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

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

iv. Medications, with the following limitations

a) The member has a prescription for the medication.

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

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

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

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

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

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

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

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

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

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

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

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

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

8.509.18 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.

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.

8.509.50 MENTAL HEALTH TRANSITIONAL LIVING HOMES

A. Definitions

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

2. Authorized Representative means an individual designated by a member, or by the parent or guardian of the member receiving services, if appropriate, to assist the member receiving services in acquiring or utilizing services and supports. This does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) or In-Home Support Services (IHSS).

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

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

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

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

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

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

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

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

B. Member Eligibility

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

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

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

C. Member Benefits

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

2. This residential service will include the following:

a. Protective oversight and supervision;

b. Assistance with administering medication and medication management;

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

d. Assistance with recreational and social activities;

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

f. Life skills training; and

g. ADL support as needed.

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

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

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

D. Member Rights

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

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

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

E. Provider Eligibility

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

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

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

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

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

F. Provider Roles and Responsibilities

1. Service Requirements

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

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

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

d. Providers shall maintain the following records/files:

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

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

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

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

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

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

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

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

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

2. Person Centered Support Plan

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

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

ii. Supports needed with ADLs;

iii. Special dietary needs, if any; and

iv. Reference to any documented physician orders.

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

3. Incident Reporting

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

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

i. Death of member receiving services;

ii. Hospitalization of member receiving services;

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

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

v. Injury to member or illness of member;

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

vii. Errors in medication administration;

viii. Lost or missing person receiving services;

ix. Criminal activity;

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

xi. Use of a rights modification.

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

i. Name of person reporting;

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

iii. Member's Medicaid identification number;

iv. Name of persons involved or witnessing the incident;

v. Incident type;

vi. Date, time, and duration of incident;

vii. Location of incident;

viii. Persons involved;

ix. Description of incident;

x. Description of action taken;

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

xii. Name of person notified;

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

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

xv. Resolution, if applicable.

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

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

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

4. Staffing

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

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

i. Mental Health First Aid.

ii. Question, Persuade, Refer (QPR).

iii. Suicide and Homicide Risk Screenings.

iv. Trauma Informed Care Methodologies and Techniques.

v. Symptom Management.

vi. Behavior Management.

vii. Motivational Interviewing.

viii. Transitional Planning.

ix. Community Reinforcement and Family Training.

G. Reimbursement

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

2. Additional Charges

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

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

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

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

8.511 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.511.1 DEFINITIONS

Definitions below only apply to Section 8.511.

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

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

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

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

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

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

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

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

8.511.2 QUALIFYING SERVICES

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

1. Adult Day Services

2. Alternative Care Facility (ACF)

3. Community Connector

4. Consumer Directed Attendant Support Services (CDASS)

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

6. Group Home Habilitation (CHRP)

7. Group Residential Support Services (GRSS)

8. Homemaker

9. Homemaker Enhanced

10. Host Home (CHRP)

11. In-Home Support Services (IHSS)

12. Individual Residential Support Services (IRSS)

13. Job Coaching

14. Job Development

15. Mental Health Transitional Living Homes

16. Mentorship

17. Pediatric Personal Care

18. Personal Care

19. Prevocational Services

20. Respite

21. Specialized Habilitation

22. Supported Community Connections

23. Supported Living Program

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

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

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

8.511.3 PROVIDER RESPONSIBILITIES

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

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

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

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

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

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

1. Payroll summaries and details, pay stubs with details

2. Timesheets

3. Paid time off records

4. Cancelled checks (front and back)

5. Direct deposit confirmations

6. Independent contractor documents or agreements

7. Per diem wage documents

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

8.511.4 REPORTING & AUDITING REQUIREMENTS

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

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

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

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

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

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

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

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

1. Definition

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

2. Post-Eligibility Treatment of Income Application

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

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

3. Case Management Responsibilities

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

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

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

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

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

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

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

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

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

d) Medications, with the following limitations:

1) The member has a prescription for the medication

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

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

4)

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

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

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

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

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

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

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

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

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

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

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

8.519 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. 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 Community Based Services- Supported Living Services (HCBS-SLS) waivers.

C. Assessment means as defined in Section 8.390.1 DEFINITIONS.

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 as defined in Section 8.390.1 DEFINITIONS.

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. 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.

N. Corrective Action Plan shall be as defined at Section 8.390.1.DEFINITIONS.

O. 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.

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

Q. Developmental Delay means as defined in Section 8.600.4.

R. Developmental Disability means as defined in Section 8.600.4.

S. Executive Director means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

T. Financial Eligibility means the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources, if applicable.

U. 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.

V. 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.

W. 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 Care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

X. 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.

Y. Information Management System (IMS) means as defined in Section 8.390.1 DEFINITIONS.

Z. 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 PCSP.

AA. Legally Responsible Persons means the parent of a minor child, or the Client's spouse,

BB. Level of Care Eligibility Determination means as defined in Section 8.390.1 DEFINITIONS.

CC. Level of Care Eligibility Determination Screen means as defined in Section 8.390.1 DEFINITIONS.

DD. 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.

EE. 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.

FF. 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.

GG. Parent means the biological or adoptive parent.

HH. 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.

II.. Person-Centered Support Plan (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

JJ. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.

KK. 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.

LL. Professional Medical Information Page (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

MM 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.

NN. 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.

OO. 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 PCSP and that the Case Management Agency complied with the requirements set forth in statute, waiver, and regulations.

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. 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 Assessment and periodic Reassessment, development and periodic revision of a PCSP, referral and related activities, and monitoring.

TT. 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.

8.519.7 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. At-Risk means a Medicaid member who lives outside of an institutional facility and has either received a Level of Care Screening to access Medicaid nursing facility services or is at risk for institutionalization as determined by the Department.

2. At Risk Diversion means a Person-Centered process through which services are arranged or provided to enable an At-Risk population member to avoid admission to an institution or institution-like setting to live instead in a less restrictive setting in the community.

3. Case Management Agency (CMA) means a public, private, or non-governmental non20 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.

4. Community Needs and Preferences Assessment means the assessment that is completed by the Transition Options Team (TOT) to ensure a comprehensive understanding of the member's health conditions, functional needs, transition needs, behavioral concerns, social and cultural considerations, educational interests, risks and other areas that may require services and/or community resource support.

5. Community Risk Level means the potential for a member living in a community-based arrangement to require emergency services, to be admitted to an institution or institution-like setting, 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.

6. Corrective Action Plan (CAP) means a written plan by the Transition Coordination Agency (TCA), and approved by the Department, which includes a detailed description of actions to be taken to correct non-compliance with regulations, and/or 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. Corrective Action Plans may be requested by the Department at any time.

7. Post-Transition Monitoring means the activities performed by a Transition Coordination Agency (TCA) that occur after a member has successfully moved into the community or has been diverted from institutionalization and is a recipient of home-and community-based services.

8. Pre-Transition Coordination means the activities by the 1 TCA that occur before a member has moved into the community to prepare the member for success in community living and integration.

9. Risk Factors mean 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.

10. Risk Mitigation Plan means the document that records the risk mitigation planning process. Risk Mitigation Plans are used to complete Pre-Transition and Diversion strategy development, conduct post-discharge monitoring of effectiveness of risk prevention strategies, document identification of additional risk factors, and revise risk incident response plans.

11. 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. Risk mitigation planning includes identifying planned actions to take in response to an adverse consequence should a risk be realized.

12. Community Needs and Preferences Assessment means the process of capturing a comprehensive understanding of the member'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.

13. Transition Coordination Services means support provided to a member who is transitioning or being diverted from a skilled nursing facility, extended SNF LOC hospital stay, intermediate care facility for individuals with intellectual disabilities, or regional center and includes the following activities: comprehensive assessment for transition or diversion, community risk assessment, development of a transition or diversion plan, referral and related activities, and monitoring and follow up activities as they relate to the transition or diversion.

14. Transition Coordinator (TC) means a person who provides Transition or Diversion Coordination Services and meets all regulatory requirements for a TC.

15. 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/diversion Coordination Transition or Diversion support pursuant to a provider participation agreement with the Department.

16. Transition Options Team (TOT) means the group of people involved in supporting and implementing the transition or diversion, to include the person receiving services, the TC, the guardian, may include the home- and community- based services case manager, nursing facility social worker and others chosen by the individual receiving services as being valuable to participate in the transition process. The TOT is convened to work in a cooperative and supportive manner to develop and implement the transition or diversion plan, and to serve in an advocacy role with the member.

17. Transition period means the period of time in which the member receives Transition Coordination for the purpose of successful integration into community living. A transition period is complete when the member has successfully established community residence and is no longer in need of Transition Coordination based on the member's community risk level, or the member or guardian requests that TCM-TC services are discontinued.

18. Transition or Diversion 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 or remaining in a community setting of their choosing.

19. Transition or Diversion Planning means the completion of the TCM-TC Community Needs and Preferences Assessment and Risk Mitigation Plan, facilitation of a transition or Diversion Recommendation, and developing a transition or Diversion Plan, in coordination with the TOT.

20. Transition Rrecommendation means a recommendation made by the TOTtransition options team regarding transition. The recommendation is made solely on availability of necessary supports and services identified by the Community Needs and Preference Assessment and the Risk Mitigation Plan.

8.519.27.B Qualifications of Transition Coordination Agencies

1. In order to be approved as a TCA, the agency shall meet all of the following qualifications:

    a. Have a physical location in Colorado.

    b. Be a public or private not for profit or for-profit agency.

    c. Demonstrate proof the agency has employed staff that meet TC qualifications.

    d. Have a minimum of two (2) years of agency experience in assisting at-risk individuals to access 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.

    e. Provide transition or diversion coordination to members who select the agency and also reside in the county/counties for which the agency has elected to provide services.

    f. Possess the administrative capacity to deliver transition or diversion coordination.

    g. Have established community referral systems and demonstrate linkages and referral ability to make community referrals for services with other agencies.

    h. Demonstrate ability to meet all applicable requirements contained within Sections 8.519.27, 8.763, the Medicaid State Plan and the provider participation agreement.

    i. Financial reserves shall match one (1) month of expenditures associated to the number of members expected through that catchment area and provide stability for TCs, members and service providers.

    j. All agencies are required to submit an audited financial statement or 1 equivalent to the Department for review upon request.

k. 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

1. In order to be approved as a TCA, the agency shall perform all of the following functions:

a. TCAs must be in compliance with all required agency performance standards and training guidelines to be in good standing with the Department. Failure to comply with required standards and training guidelines may result in suspension of referrals until a corrective plan is submitted by the TCA and approved by the Department.

b. TCAs shall be responsible to maintain sufficient documentation, as defined in TCM-TC training, of all transition or diversion coordination activities performed and to support claims within the Department designated data system and internal agency records.

c. TCAs may not provide guardianship services for any member for whom they provide transition or diversion coordination services.

d. TCAs 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 member and/or persons inquiring upon their behalf.

e. TCAs shall respond to referrals for transition coordination support within two (2) business days and within one (1) business day for diversion coordination referrals and specify whether the referral is accepted or not by completing the Transition Services Referral Form.

f. TCAs shall assign and meet with the member within ten (10) state business days after accepting a transition referral and two (2) state business days after accepting a diversion referral.

g. TCAs shall assign one (1) primary person who ensures transition or diversion coordination is provided tof the member.

h. TCAs shall provide coordination in accordance with state business days as defined in 24-11-101(1) C.R.S.

i. TCAs shall maintain all documents, records, communications, notes, and other materials that relate to any work performed.

j. TCAs shall possess appropriate financial management capacity and systems to document and track services and costs in accordance with state and federal regulations.

k. TCAs shall maintain and update records of persons receiving transition or diversion coordination in accordance with reporting requirements of the Department’s data system.

l. TCAs 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 members.

m. TCAs 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.

n. TCAs 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 statutes and regulations. TCAs shall provide transition coordination for members without discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability.

o. TCAs 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.

p. TCAs 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.

q. TCAs shall establish agency procedures sufficient to execute transition or diversion coordination according to the provisions of these regulations. Such procedures shall include, but are not limited to:

i. Referral Management

ii. Assessment of community needs and preferences

iii. Transition or Diversion Planning

iv. Risk Mitigation Planning

v. Service and support coordination for non-Medicaid transition or diversion-related services and supports

vi. Monitoring of the Risk Mitigation and Transition or Diversion Plans

vii. Denial and discontinuation of Transition or Diversion Coordination Services

viii. Management of interstate TCM-TC transfers

ix. Complaint Procedure that includes the requirement to share information, such as points of contact within the agency, to members, families and referring agencies who may wish to file a complaint

8.519.27.D Qualifications of Transition Coordinators

1. TCs must be employed by an approved TCA. TC minimum experience:

a. A bachelor's degree; or

b. Five (5) years of relevant experience in the field of LTSS, which includes Developmental Disabilities; or

c. Some combination of education and relevant experience appropriate to the requirements of the position.

d. Relevant experience is defined as:

i. 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 nonprofit 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,

ii. 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.

iii. For members for whom the TC is providing transition or diversion coordination, TCs may not:

1) Be related by blood or marriage to the member

2) Be related by blood or marriage to any paid caregiver of the member

3) Be financially responsible for the member

4) Be the member's legal guardian, authorized representative, or be empowered to make decisions on the member's behalf through a power of attorney

8.519.27.E Training

1. TCs must complete and document the following trainings within sixty (60) days from the date of hire and prior to providing transition or diversion coordination services independently, and thereafter on an annual basis:

a. Assessment of community needs/preferences and risk factors

b. Transition or Diversion Planning

c. Risk Mitigation Plan development, monitoring and revision

d. Referral 1 for non-Medicaid services

e. Monitoring services

f. Case documentation

g. Person-centered approaches to planning and practice

h. Housing voucher application and housing navigation services

8.519.27.F Functions of Transition Coordinators

1. TCs must perform all the following activities. These activities are the only activities billable under transition coordination:

    a. Coordinate (TOT) activities including:

        i. Facilitate completion of an assessment which identifies preferences, needs and any risk factors the member may have in a community-based setting within six (6) weeks of first meeting with the member for a Transition Plan and within one (1) week of first meeting with the member for a Diversion Plan.

        ii. Facilitate development of a Risk Mitigation Plan to address identified risk factors within eight (8) weeks of accepting a transition referral and two (2) weeks of accepting a diversion referral.

        iii. Identify supports and services that will be required to address the member's needs, preferences, and risk factors.

        iv. Complete a transition recommendation from the TOT within six (6)weeks of first meeting with the member but not before the first TOT meeting.

        v. Facilitate completion of a Transition or Diversion Plan if the member chooses to proceed with the transition or diversion

    b. Conduct Pre-Transition or Diversion Coordination including:

        i. Facilitate completion of transition or diversion assessment, Risk Mitigation and Transition or Diversion Plans

        ii. Complete, as needed, housing voucher application, including assistance to obtain necessary documents

        iii. Collaborate, as needed, with housing navigation services to obtain a voucher and locate housing

        iv. Assist member to create a transition or diversion budget

        v. Collaborate with housing navigation services, Division of Housing, voucher administrators and property managers to establish a community-based living arrangement for eligible members.

        vi. Coordinate any medication, home modification and/1 or durable medical equipment needs with the nursing facility or HCBS case manager prior to discharge to ensure that all components of the Transition or Diversion Plan are in place prior to discharge

        vii. Assist member in preparing for discharge, including being present at the nursing facility on the day of discharge to ensure requirements of discharge plan are addressed

        viii. Meet with the member at their home on the day of discharge to ensure that providers and services needed upon discharge are in place and the household set-up is complete

c. Conduct Post-Transition or Diversion Monitoring that meets the member's need as documented in the risk mitigation plan and occurs at the frequency and type to meet the member's community risk level Post-Transition or Diversion monitoring includes:

i. Ensuring that members receive services in accordance with their Transition/Diversion Plan and Risk Mitigation Plan

ii. Post-Transition or Diversion Monitoring may include as determined by the community risk level:

1) Face-to-face in the member's residence

2) Face-to- face in the community.

3) By telephone, electronic, video or virtual communication

d. Post-Transition or Diversion Monitoring includes:

i. Provision of support services to aid in sustaining community-based living

ii. Response to risk incidents and notifying the CMA and Adult Protection Services (APS) as required

iii. Revision of Risk Mitigation Plan as needed

iv. Assessing the need for independent living skills training

v. Problem-solving community integration issues

vi. Supporting community integration activities

vii. Monitoring service provision, to include contacting guardians, providers, and case management agencies

viii. Requesting that member completes a TCM-TC satisfaction survey prior to discharge and at the end of the transition or diversion period to evaluate the member's experience of the following:

1) Transition or Diversion Planning

2) Transition or Diversion Plan implementation

3) Transition or Diversion Coordination process

4) Level and adequacy of services provided

5) Overall member satisfaction

e. Post-transition or Diversion 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 Transition Coordination Agencies Approval

1. A TCA shall maintain Department provider approval in accordance with quality assurance standards and requirements set forth in the Department's rules and direction. Department approval is needed for continued receipt of TCM-TC referrals.

    a. Approval as a TCA shall be based on an evaluation of the agency's performance in the following areas:

        i. The frequency of requests for TCA changes and/or complaints received by the Department pertaining to agency performance;

        ii. The agency's compliance with program requirements, including compliance with transition coordination standards adopted by the Department;

        iii. The agency's performance of administrative functions, including, timely reporting, program management, on-site visits to individuals, community coordination and outreach and individual monitoring;

        iv. Financial accountability;

        v. The maintenance of qualified and trained personnel to perform transition coordination duties;

        vi. Continual performance and quality assurance activities; and

        vii. Overall member satisfaction as indicated by member satisfaction surveys.

2. The Department or its designee shall conduct reviews of the TCA.

    a. At least sixty (60) days prior to expiration of the previous approval date the Department shall notify the TCA of the outcome of the review, which may be approval, provisional approval, or denial of approval.

    b. The Department shall conduct evaluations as needed based on incidents of member, nursing facility and/or provider complaints regarding TCA performance and/or non-compliance with TCM-TC agency requirements.

8.519.27.H Conflict of Interest for Transition Coordination Agencies

1. If a TCA 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 members. The HCBS case management agency shall be responsible for all service brokering for Medicaid HCBS 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.

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 Pediatric Personal Care providers are required to comply with all Base Wage requirements established in Section 8.511.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.1 DEFINITIONS

A. Designated Representative means a person appointed by the member to act on their behalf for healthcare and treatment decisions as documented in the member's advanced healthcare directive or other comparable documentation.

B. Family/In-Home Caregiver means an individual who assumes a portion of the member's care in the home in the absence of agency staff. A Family/In-Home Caregiver may either live in the member's home or travel to the member's home to provide care.

C. Group Nursing means the provision of Private Duty Nursing services by a Registered Nurse or Licensed Practical Nurse to more than one member at the same time in the same home or community-based setting.

D. Home Health Agency (HHA) means an agency or organization that is certified for participation as a Medicare Home Health provider pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider as required by § 25-27.5-103(1), C.R.S.

E. Medical Necessity is as defined in Program Integrity rules at Section 8.076.1.8. For children 20 and younger, this is further defined to include the requirements set forth in the Early and Periodic Screening, Diagnosis, and Treatment rules at Section 8.280.1.

F. PDN Nursing Assessment means an individualized comprehensive assessment completed by the HHA case coordinator that accurately reflects the member's current health status and includes information that may be used to demonstrate the member's progress toward achievement of the desired outcomes. The comprehensive assessment shall identify the member's need for home care and meet the member's medical, nursing, rehabilitative, social, and discharge planning needs.

G. Physician or Allowed Practitioners means an enrolled physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) who oversees the delivery of skilled care to a member within their scope of practice as set forth at Colorado Revised Statutes, Title 25, Articles 240 or 255, as applicable.

H. Plan of Care (POC) means a completed Centers for Medicare and Medicaid Services (CMS) Form 485, also referred to as a care plan, developed by the HHA in consultation with the member, that has been ordered by the physician or allowed practitioner for the provision of services to a member at his/her residence or community setting, and is periodically reviewed and signed by the physician or allowed practitioner in accordance with Medicare requirements at 42 CFR § 484.60.Private Duty Nursing (PDN) means medically necessary nursing services that are more individual and continuous care than is available under the Home Health benefit, or routinely provided by the nursing staff of a hospital or skilled nursing facility, that allow a member to remain in their home or community-based setting.

I. Private Duty Nursing (PDN) means medically necessary nursing services that are more individual and continuous care than is available under the Home Health benefit, or routinely provided by the nursing staff of a hospital or skilled nursing facility, that allow a member to remain in their home or community-based setting.

J. Re-Hospitalization means any hospital admission that occurs after the initial hospitalization for the same condition.

K. Skilled Nursing/Skilled Nursing Service means services provided under the licensure, scope, and standards of the Colorado Nurse and Nurse Aide Practice Act, § 12-255-101, C.R.S., performed by a registered nurse (RN) under the direction of a physician or allowed practitioner, or a licensed practical nurse (LPN) under the supervision of a RN and the direction of a physician or allowed practitioner, for care that cannot be delegated by the judgment of the RN or LPN.

L. Technology Dependent means the daily use of medical devices or procedures to maintain a bodily function without which adverse health consequences creating further disability, hospitalization or death could likely follow.

M. Utilization Review Contractor (URC) means a third-party vendor contracted by the Department to perform utilization management functions for specific services.

8.540.2 CRITERIA FOR SERVICES

8.540.2.A To receive PDN services, a member must receive an approved PAR as set forth in Section 8.540.6 and satisfy the following criteria:

1. The member is able to be safely served in their home or community setting by a HHA under the agency requirements and limitations of the PDN benefit and with the staff services available.

2. The member is not residing in a nursing facility or hospital at the time PDN services are delivered.

3. The member has previously been determined to be eligible for the medical assistance program pursuant to Section 8.100.

4. The member meets one of the following criteria:

   a. Members aged 21 years or older who demonstrate medical necessity for Skilled Nursing Services in accordance with Section 8.076.1.8, are technology dependent, and for whom a delay in skilled nurse-level interventions would result in deterioration of a chronic condition, loss of function, imminent risk to health status due to medical fragility or risk of death.

   b. Members aged 20 years or younger who demonstrate medical necessity in accordance with Early and Periodic Screening, Diagnostic, and Treatment benefits requirements at Section 8.280.4.E.

      i. Members age 20 years or younger shall require skilled nursing assessment, intervention, and evaluation of both equipment (if applicable) and member.

      ii. The services provided shall be medical in nature, safe, effective, generally recognized as an accepted method of treatment, not experimental/investigational, cost-effective, necessary for care of a member's condition, and within accepted standards of nursing practice.

8.540.3 BENEFITS

8.540.3.A All PDN services require prior authorization as set forth in Section 8.540.6-7.

1. The ongoing need for PDN care shall be re-evaluated annually, at a minimum, or when necessary due to a change in the member's condition. The Department, in coordination with the URC, determines the number of PDN hours based on documented medical necessity. PDN hours may be increased or reduced when necessitated by a change in the member's condition as documented in the member's medical record.

2. Authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Reimbursement for PDN claims requires that the member have active coverage on the date of service. Submitted claims shall comply with current billing policies effective on the date of service as set forth in the Home Health Billing Information Manual.

3. A member's need for skilled nursing care is determined based solely on their unique condition and individual needs at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

4. Authorized PDN hours shall be used only to meet the medically necessary needs as described in the POC and approved prior authorization request (PAR).

8.540.3.B A pediatric member aged 20 or younger may be approved for up to 24 hours per day of PDN services if the member meets the URC medical necessity criteria defined at Section 8.540.1.E.

8.540.3.C Adult members aged 21 or older may be approved up to 23 hours per day of PDN services if the member meets medical necessity criteria defined at Section 8.540.1.E.

8.540.3.D A member may be eligible for a short-term increase in PDN services for a change of condition. The HHA shall apply for additional hours through a revision to the original PAR.

8.540.3.E A member who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the member's activities of daily living take him or her away from the home. The total hours authorized shall not exceed those that would have been authorized if the member received all care in the home.

8.540.4 BENEFIT LIMITATIONS

8.540.A A member who meets both the eligibility requirements for PDN and home health shall be allowed to choose whether to receive care as either a PDN or Home Health benefit. The member 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 member.

8.540.4.B Total hours of PDN services shall not exceed what has been determined medically necessary by the URC and ordered by the physician or allowed practitioner.

8.540.4.C PDN services shall not be authorized under the following circumstances:

1. The services consist of assistance with activities of daily living or other non-skilled services.

2. The physician's or allowed practitioner's treatment plan does not identify the need for skilled nursing.

3. The services consist of observation or monitoring for medical conditions not requiring skilled nursing assessment and intervention, as documented in the physician's or allowed practitioner's treatment plan and/or nursing notes.

4. The PDN services are used solely for the convenience of the member or other caregiver.

5. The services are custodial or stand-by care to ensure compliance with treatment.

6. The services are intended for other members of the household who are not receiving approved, group PDN services.

7. The services are duplicative of care covered by another benefit or funding source.

8.540.4.D HOSPITAL DISCHARGE PROCEDURES

1. The hospital discharge planner shall plan for the member's hospital discharge by coordinating with the HHA to:

   a. Arrange services with the HHA, medical equipment suppliers, counselors and other healthcare service providers as needed.

   b. Coordinate a safe home care plan in conjunction with the physician or allowed practitioner and the HHA that meets program requirements.

   c. Advise the HHA of any changes in medical condition and care needs.

   d. Ensure that the member, family and caregivers are educated about the member's medical condition and trained to perform the home care in the absence of HHA staff.

8.540.5 PROVIDER AND FAMILY REQUIREMENTS

8.540.5.A. Provider Eligibility

1. HHA services shall be provided by an HHA certified for participation pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider pursuant to § 25-27.5-103(1), C.R.S.

2. All Home Health Agency providers shall comply with applicable regulations promulgated by the Board of Health, Medical Services Board, Medical Board, Nursing Board, Department of Labor and Employment, and the Centers for Medicare and Medicaid Services.

8.540.5.B Provider Agency Requirements

1. An HHA shall:

   a. Be certified for participation as a Medicare Home Health provider pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider as required by § 25-27.5-103(1), C.R.S.;

   b. Be a Colorado Medicaid enrolled provider;

   c. Maintain liability insurance for the minimum amount set annually as set forth at 6 CCR 1011-1, Chapter 26, Section 4.2; and

d. Hold a State of Colorado Class A Home Care Agency license in good standing.

2. Home Health Agencies that perform tests in the member's home that are identified as eligible for a Clinical Laboratory Improvement Amendments (CLIA) waiver pursuant to 42 C.F.R. § 493.15 shall possess a certificate of waiver from CMS or its Designee.

3. A HHA shall not discontinue or refuse services to a member unless documented efforts have been made per agency policies to resolve the situation that triggers the discontinuation or refusal. The HHA shall provide at least 30 calendar days advance notice to the member or the member's designated representative.

4. In the event an HHA ceases operations, it shall notify the Department within 30 calendar days. The notification shall be submitted through the Provider Portal as a maintenance application for the disenrollment request. The provider shall also email the notice to the Department at the designated Home Health email inbox.

8.540.5.C. Provider Responsibilities

1. A certified HHA that provides PDN services shall meet all of the following:

a. Employ nursing staff nursing staff licensed to practice in Colorado pursuant to the Nurse and Nurse Aide Practice Act, § 12-255-101, C.R.S. that possess education and experience in providing care to individuals who require skilled nursing care in a home or community-based setting in accordance with HHA policy, state practice acts, and professional standards of practice

b. Employ nursing personnel with documented skills, training and/or experience appropriate for the member's individualized needs and care requirements, including cultural and disability competency.

c. Provide appropriate nursing skills orientation and ongoing in-service education to nursing staff to meet the member's specific nursing care needs.

d. Require nursing staff to complete cardiopulmonary resuscitation (CPR) instruction and certification at least every two years.

e. Provide adequate supervision and training for all nursing staff as required by the agencies listed in Section 8.540.5.A.2. To be reimbursed for time billed, nursing staff shall be engaged in an activity that directly benefits the member receiving services. Staff shall be physically able and mentally alert to carry out the duties of the job.

f. Coordinate services with a supplemental certified HHA, if necessary, to meet the staffing needs of the member.

g. Designate a case coordinator who is responsible for the management of private duty nursing services,

h. Develop the individualized care plan by completing the PDN nursing assessment and obtaining information from the attending physician or allowed practitioner and the primary caregiver.

i. For members discharging from a hospital, include information from the discharge planner in the care planning process.

j. Assess the home prior to the initial start of services or hospital discharge and on an ongoing basis for safety compliance.

k. Involve the member and Family/In-Home Caregiver in the plan for home care and the provision of home care.

l. Assist the member to reach maximum independence.

m. Communicate changes in the member's status with the physician or allowed practitioner 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, and revise the PAR if a change in services is required to meet the member's changed needs.

n. Assist with communication and coordination between the service providers supplementing the primary HHA, the primary care physician or allowed practitioner, specialist(s) and the primary HHA as needed.

o. Make regular on-site visits according to HHA policies and procedures and professional standards of practice to monitor the safety and quality of home care and make appropriate referrals to other agencies for care as necessary.

p. Ensure that a complete and current care plan prepared within the prior 60 days and nursing chart are in the member's home at all times. The nursing chart shall include interim physician or allowed practitioner orders, current medication orders and nursing notes. Records of treatments and interventions shall clearly show compliance with the care plan.

q. Communicate with the Case Management Agency and/or Regional Accountability Entity as needed regarding service planning and coordination.

r. Make and document the efforts made to resolve any situation that triggers a discontinuation of or refusal to provide services prior to discontinuation or refusal to provide services.

8.540.5.D. Family/In-Home Caregiver Responsibilities

1. The HHA shall inform the member and their Family/In-Home Caregiver of the following responsibilities for PDN services and ensure that the caregiver:

a. Is able to assume some portion of the member's care when agency staff is not available.

b. Has the specific skills necessary to care for the member.

c. Has completed CPR instruction or certification and/or training specific to the member'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 or allowed practitioners as needed.

g. Works toward the member'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 person relying on skilled nursing in the household.

8.540.5.E. Environmental Requirements

1. Prior to providing PDN services, the HHA shall perform an in-home assessment and document that the home meets the following safety requirements:

a. Adequate electrical power, including a backup power system.

b. Adequate space and ventilation 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 member's life or health is not at risk.

e. A working phone available 24 hours a day.

8.540.5.F. Physician or Allowed Practitioner Role

1. The HHA shall coordinate with the member's attending physician or allowed practitioner to:

a. Determine that the member is medically stable, except for acute episodes that may be managed by PDN services, and that the member may be safely served within the requirements and limitations of the PDN benefit.

b. Cooperate with the URC in establishing medical eligibility.

c. Prescribe a plan of care at least every 60 days.

d. Coordinate with any other physician(s) or allowed practitioner(s) treating the member.

e. Communicate changes in the member's medical condition and care, including discharge from the hospital.

f. Empower the member and the Family/In-Home Caregiver by working with them to maximize the member's independence.

8.540.6 PRIOR AUTHORIZATION PROCEDURES

8.540.6.A A PAR is required for all PDN services. Prior authorization is a request for medically necessary services, based on the needs of the member. The presence of additional members in the home shall not impact the individual member's medical necessity determination.

8.540.6.B The PAR may be approved for up to six months for a new member and up to one year for ongoing care.

8.540.6.C The PAR shall include the following:

1. A current POC on CMS Form 485, or form of similar format, that summarizes health conditions, specific care needs, and current treatments, signed by the physician or allowed practitioner or a documented verbal order. The POC shall include::

    a. A signed PDN Nursing Assessment, a current clinical summary or 60-day summary of care, orders for all disciplines and treatments signed by the physician or allowed practitioner, and goals of care/rehabilitation potential, if applicable.

    b. A current diagnosis list and medication list including PRN medications.

    c. A documented process by which the member receiving services and support may continue to receive necessary care, which may include backup care, if the member's Family or In-Home Caregiver is unavailable due to an emergency situation or unforeseen circumstances. The Family or In-Home Caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.

    d. A hospital discharge summary if there has been a hospitalization since last PAR.

2. Identification of professional disciplines supporting the medical needs of the member in the home and responsible for the delivery of care. If care overlaps, documentation shall identify overlapping care and the rationale for the overlap.

3. For new members approved for PDN directly upon discharge from the hospital, a copy of the transcribed verbal physician or allowed practitioner orders may be substituted for the POC.

4. Documentation submitted shall include sufficient information to demonstrate the medical necessity of Skilled Nursing Services. The number of hours authorized may differ from the number of hours requested based on the clinical review of the request and supporting documentation. The HHA shall not misrepresent or omit facts in a treatment plan.

5. If a member's condition necessitates a change in PDN hours, the HHA shall submit a PAR revision request within 10 business days of a change. The revision may be an increase or a decrease in hours. Discharge notification is also required within 10 business days via a PAR revision request.

6. In the event a member changes provider agencies, the receiving HHA shall submit a Change of Provider Form and POC to the URC within 10 business days of starting PDN services.

7. In the event of limited nursing resources for a HHA, two HHAs may coordinate care and provide services to the same member as long as there is no duplication of services on the same date(s) of service and the HHAs comply with the following:

    a. The HHAs shall document the need and reason for two HHAs to render services to a member.

    b. The two HHAs shall coordinate the member's POC and maintain the POC and documentation on all services rendered by each PDN Provider in the member's records.

    c. Each HHA shall obtain prior authorization, identify to the URC the coordinated POC and revise the PAR as needed to ensure coverage.

8.540.7 UTILIZATION REVIEW

8.540.7.A Providers shall submit requests for prior authorization of PDN services directly to the URC within 10 business days of starting PDN services. Incomplete requests shall be held in pending status for up to 10 business days for the provider to submit additional, required information.

8.540.7.B The criteria for approval of PDN services are based upon the submission of records that demonstrate the skilled nature of the nursing care needed, including physician and/or allowed practitioner records, specialty notes, and nursing notes. The URC shall review requests for prior authorization according to the information submitted and the application of the medical criteria as described herein.:

1. The URC shall consider combinations of technologies and co-morbidities when making medical determinations that would qualify the member for care pursuant to EPSDT exceptions to benefit limits and coverage standards. The medical judgment of the attending physician or allowed practitioner and the URC shall be used for an individual determination whenever the medical criteria are not defined by specific measurements.

2. Within 10 business days of receipt of the complete PAR, the URC shall approve or deny the PAR, or refer the PAR to the URC physician reviewer.

3. The URC shall process the physician review referrals and approve, partially approve, or deny the PAR within 10 business days of referral to the physician reviewer.

8.540.7.C The URC shall issue written notification of all PAR denials, including a member's appeal rights, to the member or member's designated representative and the submitting provider within one business day of the determination.

1. The HHA may request reconsideration by the URC if the PAR is only partially approved or is denied. The HHA also may request a Peer-to-Peer review if the ordering physician or allowed practitioner agrees.

2. Services provided during the period between the provider's submission of the PAR to the URC through the final approval or denial by HCPF may be approved for payment. Payment may be made retroactive to the start date on the PAR form or for up to 30 calendar days prior to PAR approval, whichever is shorter.

3. When a PAR determination results in the reduction or termination of services, services shall be approved for 30 additional calendar days after the date on the member's notice of denial letter. If the termination or reduction of PDN services is appealed by the member in accordance with Section 8.057, services shall be maintained at the previously approved level for the duration of the appeal until the final agency action is rendered.

4. For appeals of an initial PAR denial, continuation of benefits is not applicable.

8.540.7.D Expedited PAR reviews may be requested in situations where adhering to the time frames above would seriously jeopardize the member's life or health.

8.540.8 REIMBURSEMENT

8.540.8.A No skilled services shall be authorized or reimbursed if the skilled hours of service, regardless of funding source, total more than 24 hours per day for members aged 20 or younger and no more than 23 hours per day for members aged 21 or older.

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 HHA to submit claims to the Medicaid fiscal agent for authorized PDN services provided during the authorized period. Payment of claims is conditioned upon the member's benefit eligibility on the date 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, except as provided in Section 8.540.7.C.2.

8.540.8.E Skilled Nursing services provided as a PDN benefit shall be reimbursed in units of one hour at the lesser of the provider's usual and customary charge or the maximum Medicaid allowable rates established by HCPF.

1. Units of one hour may be billed for RN or LPN.

2. The RN group rate shall be utilized when a registered nurse is providing PDN services to more than one member at the same time in the same setting.

3. The LPN group rate shall be utilized when a licensed practical nurse is providing PDN services to more than one member at the same time in the same setting.

4. The blended RN/LPN rate shall be requested by the HHA when utilizing an RN or LPN as the assigned staff for more than one member at the same time in the same setting.

5. PDN services may be provided by a single nurse to an individual or to multiple individuals in a non-institutional group setting as described above. The nurse-member ratio shall not exceed what is required for one licensed nurse to safely care for each member simultaneously, based on member acuity and the availability of additional support in the home.

8.540.8.F Reimbursement shall not be allowed at any time when nursing staff is sleeping during the provision of PDN services.

8.540.8.G No individual nurse shall be reimbursed for over 16 hours of care per day, except in a documented emergency situation.

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 LOC Screen. 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.

8.552 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 $2,000 per eligible member. The Department may authorize additional funds above the $2,000 limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member.

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.

8.555 Money Follows the Person (MFP) Demonstration

8.555.1 Program Overview

8.555.1.A Program Definition, Authority, and Scope

1. Program Definition

   a. Money Follows the Person is a federal grant that supports state strategies to rebalance their long-term services and supports (LTSS) systems from institutional to community-based care. MFP plays a key role in LTSS rebalancing efforts under the Medicaid program. The program provides flexible funding opportunities to help states develop and test the necessary processes, tools, and infrastructure to advance LTSS system reform and to support successful transitions from institutional to community-based settings for individuals eligible for Medicaid LTSS. The model demonstrates the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches to promote the objective of the Medicaid program.

2. Legal Authority

   a. The federal authority for the MFP demonstration is section 6071 of the Deficit Reduction Act of 2005 (DRA). Section 6071 of the DRA has been amended by: section 2403 of Patient Protection and Affordable Care Act; section 2 of the Medicaid Extenders Act of 2019; section 5 of the Medicaid Services Investment and Accountability Act of 2019; section 4 of the Sustaining Excellence in Medicaid Act of 2019; section 205 of the Further Consolidated Appropriations Act, 2020 (CAA); section 3811 of the Coronavirus Aid, Relief, and Economic Security Act, 2020; section 2301 of the Continuing Appropriations Act, 2021 and Other Extensions Act; section 1107 of the Further Continuing Appropriations Act, 2021, and Other Extensions Act; and section 204 of the Consolidated Appropriations Act, 2021 (CAA).

   b. MFP is designed to complement the services offered through the Home and Community-Based Services (HCBS) waivers authorized through Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n).

   c. The State Authority for the Rule is in C.R.S. § 25.5-6-1501(6).

3. Scope and Purpose

   a. The MFP program assists members residing in qualified institutions with exploring their community-based options for long term supports and services; facilitates the transition of members to a community setting so long as the right services and supports can be arranged in the community to ensure the health, welfare, and safety of the member; and provides enhanced services and supports through willing and qualified providers.

   b. The MFP program strengthens the transition process for members of qualified institutions and provides additional support and services for a successful transition. These additional supports and services fall into the categories of demonstration services or supplemental services.

   c. Demonstration Assurances:

i. Services will be made available throughout the entirety of the demonstration and last for 365 calendar days, 366 days during a leap year if applicable, following discharge to a qualified residence.

ii. Services offered under the demonstration will not duplicate any existing benefits, and adequate services definitions will create role clarity for those involved in the processes.

iii. Outreach and training will be provided to build awareness of the services offered under the demonstration to include program goals, documentation, and quality oversight.

iv. Successful completion of the demonstration will include authorization of HCBS services needed for continuity of care following the demonstration period.

8.555.1.B Definitions

1. Case Management means the Assessment of an individual seeking or receiving Long-Term Services and Supports' needs, the development and implementation of a Person-Centered 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 and collaboration with other entities impacting the Members' HCBS, health and welfare.

2. Demonstration Services for the purposes of the MFP demonstration means Targeted Case Management - Transition Coordination (TCM-TC) where support will be available to members upon confirmation of member eligibility and for 365 calendar days following discharge from the qualified institution. Need for demonstration services will be identified by the TCM-TC Community Needs and Preference Assessment and Risk Mitigation Plan.

3. Division of Housing (DOH) is the State entity within the Department of Local Affairs (DOLA) that represents the housing authority for MFP programs through an Interagency Agreement (IA) with the Department of Health Care Policy and Financing (HCPF)

4. Qualified institution means a nursing facility; intermediate care facilities for individuals with intellectual disabilities (ICF-IID); Regional Center (RC) or institutions for mental diseases (IMD), which include Psychiatric Hospitals only to the extent medical assistance is available under the State Medicaid plan for services provided by such institutions.

5. Qualified residence means a home owned or leased by the member or the member's family member; a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside; or an apartment with an individual lease, eating, sleeping, cooking, and bathing areas, lockable access and egress, and not associated with the provision or delivery of services.

6. Qualified services mean services that are provided through an existing HCBS waiver and may continue if needed by the member and if the member continues to meet eligibility for HCBS at the end of his or her enrollment in MFP.

7. MFP Supplemental Services mean services not otherwise available under Medicaid but that directly support a member through one-time or short-term expenses. Supplemental Services are reimbursable for up to six months while the member resides in a qualified institution and for a period of up to six months following discharge to a qualified residence. Need for Supplemental Services will be identified by the TCM-TC Community Needs and Preference Assessment and Risk Mitigation Plan.

8. Targeted Case Management – Transition Coordination (TCM-TC) services means transition coordination assistance provided to a member who is transitioning from a skilled nursing facility, extended SNF LOC hospital stay, 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

9. Transition Assessment/Plan means an assessment of member needs completed by a transition coordinator prior to a transition and the corresponding plan developed by the coordinator to meet the needs of the member in a community-setting post-transition.

10. Transition Coordinator (TC) means a person who provides Transition Coordination Services and meets all regulatory requirements for a TC at Section 8.519.27.

11. Transition Coordination Agency (TCA) means a public or private not-for-profit or for-profit agency that meets state and federal requirements at Section 8.519.27 and 8.763 and is certified by the Department to provide Targeted Case Management – Transition Coordination (TCM-TC) services pursuant to a provider participation agreement with the Department.

12. Transition Options Team (TOT) means a group of individuals who have a personal or professional relationship with the member who is exploring their options for community living. This group is responsible wholly or in part for the transition assessment, transition plan, determining whether the transition is recommended, completing the service plan, and brokering services.

8.555.2 Eligibility

8.555.2.A. Eligible Persons

1. MFP services shall be offered only to persons who meet all of the following eligibility requirements:

   a. Members shall be aged 18 years or older.

   b. Members shall have resided in a qualified institution for a period of 60 days or more. Days in a nursing facility for a rehabilitation stay will count towards the 60 days.

2. Members shall be Medicaid eligible

3. Members shall reside in a qualified residence post-transition.

4. MFP members admitted to a nursing facility or hospital for 30 consecutive days or longer, post-transition, shall be discontinued from the MFP program but may have the option to re-enroll once they meet all eligibility requirements. The Department has the right to exempt the 30-day exclusion on a case-by-case basis where failure to do so would result in health and safety concerns, loss of housing, loss of caregivers, or loss of benefits.

    a. MFP members entering a nursing facility for Respite Care as a qualified HCBS waiver service shall not be discontinued from the MFP program.

5. Members who reside in a residence that is not a Qualified Residence as defined in Section 8.555.1 are not eligible for MFP services.

8.555.2.B Financial Eligibility

1. Members shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual of the Colorado Department of Health Care Policy and Financing regulations at Section 8.100, Medical Assistance Eligibility.

8.555.2.C Level of Care Criteria

1. Members shall require long-term support services at a level comparable to services typically provided in a hospital, nursing facility, or ICF-IID in accordance with the waiver to which they will enroll upon transition.

8.555.2.D. Need for MFP Services

1. Members will be eligible for the MFP program when all eligibility criteria listed in Section 8.555.2. have been met.

    a. The desire or need for any Medicaid services other than MFP demonstration services, as listed at Section 8.555.1, or qualified services offered through one of the waiver programs listed in Section 8.555.2 shall not satisfy this eligibility requirement.

2. Eligible services include but are not limited to Transition Coordination, Peer Mentorship, Pre-tenancy Support, and Environmental Adaptations.

3. Once enrolled, members who have not received demonstration or qualified services for a period greater than 30 consecutive days shall be discontinued from the program.

4. MFP members will be eligible to receive all MFP Supplemental Services identified as a need during MFP enrollment

8.555.3 MFP Demonstration Program

8.555.3.A Program Duration

1. MFP members may be enrolled in the demonstration and receiving TCM-TC Services for a period of 365 days, 366 days during a leap year if applicable, following discharge from a qualified institution. After discharge the member may be enrolled in the appropriate long-term care program.

2. Following discharge from a qualified institution, MFP members will be concurrently enrolled in the MFP program and one of the following waivers:

a. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) (Section 8.7101.);

b. Home and Community Based Services Complementary and Integrative Health (HCBS-CIH) (Section 8.7101.)

c. Home and Community Based Services for People with Brain Injury (HCBS-BI) (Section 8.7101.);

d. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) (Section 8.7101.);

e. Home and Community Based Services for the Developmentally Disabled (HCBS-DD) (Section 8.7101.; or

f. Home and Community Based Services for Supported Living Services (HCBS-SLS) (Section 8.7101.).

3. At the end of the 365-day enrollment period for the MFP program, HCBS case managers will disenroll members from the program.

a. TCM-TC Demonstration services will terminate at the end of the 365 days of MFP enrollment period.

b. Supplemental services will end 6 months after discharge.

c. After MFP concludes, if members continue to meet eligibility requirements at the time of the Continued Stay Review (CSR) for one of the waivers listed in Section, 8.555.3, case managers will arrange for the continuation of qualified HCBS services through the appropriate waiver. For members that do not meet eligibility requirements for one of the waivers listed in Section 8.555.4, case managers will provide referrals to alternate resources that may include Medicaid state plan benefits.

8.555.3.B MFP Demonstration Service

1. Targeted Case Management - Transition Coordination (TCM-TC)

a. Transition Coordination will be provided in accordance with requirements defined in Transition Coordination Services Section 8.519.27.

b. Eligibility

i. Members will be eligible for MFP Transition Coordination services when all eligibility criteria described in Targeted Case Management - Transition Coordination (TCM-TC) Section 8.519.27, 8.763 and 8.555.2 are met.

c. Inclusions

i. Transition Coordination will ensure that members meet all eligibility requirements identified in Section 8.555.2 prior to enrollment.

ii. Transition Coordination shall facilitate the completion of the Department approved Transition Assessment/Plan for each member with the support of the Transitions Options Team members. The need for MFP supplemental services will be determined through this assessment process.

d. Exclusions

i. Reimbursement for mileage, travel, or transportation

e. Provider Requirements

i. Transition Coordination Agencies will follow all policies and procedures defined in Section 8.519.27 and made available through training and other guidance.

f. Provider Reimbursement

i. TCM-TC services will be reimbursed according to requirements outlined in Section 8763 and the Targeted Case Management - Transition Coordination (TCM-TC) Billing Manual.

ii. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

2. MFP Housing Assistance

a. MFP Supplemental service that provides funding for MFP members while long-term solutions are established. Colorado administers State-funded housing resources that provide members with housing vouchers. MFP Housing Assistance supports members in urgent situations while long-term State-funded options are pending or unavailable.

b. Eligibility

i. Members who have identified housing payments as a need during MFP enrollment will be eligible for six months of total rental payments through MFP Housing Assistance. MFP Housing Assistance recognizes rental arrears and monthly rental payments as eligible expenses where the combination of the two types of payments cannot exceed six months of total MFP Housing Assistance payments.

ii. Will be documented by the TCA and reported to the Division of Housing (DOH) who will be responsible for authorizing the start date and amount of monthly MFP Housing Assistance payments and subsequent State-funded housing assistance.

c. Inclusions

i. Activities reimbursable as short-term rental assistance

1) Monthly rental payments:

2) Will be calculated based on State-funded housing standards

3) Will be administered and tracked by the DOH who will be responsible for implementing State-funded housing assistance for members to avoid any interruption of payment following the member's eligibility period for MFP Housing Assistance.

ii. Rental arrears:

1) Rental arrears payments are eligible expenses under MFP Housing Assistance and will offset funding available for rental assistance following transition.

2) Rental arrears payments will not exceed six months of calculated MFP Housing Assistance.

iii. Activities reimbursable for payment prior to transitioning

1. Security Deposit

2.

d. Exclusions

i. Any MFP Housing Assistance to exceed a combination of six months of rental payments

ii. Expenses for home furnishings or grocery items

iii. Payment for modifications or accessibility adaptations to the home associated rental and utility fees identified during transition planning

e. Provider Requirements

i. MFP Housing Assistance will be administered by the Division of Housing (DOH) as a State entity within the Department of Local Affairs (DOLA) through an Interagency Agreement (IA) with the Department of Health Care Policy and Financing (HCPF) and/or HCPF Department staff or contracts.

f. Provider Reimbursement

i. MFP Housing Assistance payments will be made by the State's designated entity to landlords and/or property management groups.

ii. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

3. MFP Food Assistance

a. MFP Supplemental Service that provides short-term funding for food pantry items, community meal programs, and food boxes. This service will ensure that a member has access to food while adjusting to community-living. Funding will be available for MFP Food Assistance for 30 days following transition to the community

b. Eligibility

i. Members who have identified food as a need during MFP enrollment will be eligible for MFP Food Assistance for a period of 30 days following transition to the community

c. Inclusions:

i. Food pantry stocking items may include:

1) Perishable food items

2) Non-perishable food items

3) Nutritional vitamins and other meal supplements

4) Nutritional items associated with dietary restrictions

5) Food preparation items

ii. Community meal delivery fees for non-Medicaid resources prior to authorization of HCBS Home Delivered Meals (HDM) or other long-term alternatives. Membership fees for community programs such as Meals on Wheels or food boxes would be an example of appropriate costs under this category

d. Exclusions

i. The combination of costs associated with Short-term Food Assistance will not exceed $500 per member for the 30-day period.

ii. HCBS Home Delivered Meals

iii. Any costs that exceeds the member's MFP Food Assistance eligibility period

e. Provider Requirements

i. MFP Food Assistance providers will be subject to the standards outlined in Section 8.7549.

f. Provider Reimbursement

i. MFP Food Assistance must not exceed $500 per eligible member for a period of 30 days following discharge from a qualified institution

ii. Funding provided will not duplicate any other food expenses covered by Medicaid

iii. The total amount will be prior authorized in the State's MMIS system and will be reimbursable upon delivery of service

iv. Reimbursement for MFP services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.

1) The statewide fee schedule for these services is reviewed annually and published in the provider billing manual.

2) Reimbursement for MFP services is also conditional upon:

a) The member's eligibility for MFP services;

b) The provider’s certification status; and

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

v. Payments will be made by agencies designated by contract with the State to provide this service

vi. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department

4. MFP Pre-Tenancy Support

a. MFP Supplemental Service that teaches members how to satisfy the requirements of community-based tenancy through education and direct support. The service teaches members how to successfully secure and maintain community housing and avoid unnecessary returns to higher levels of care.

b. Eligibility:

i. Members who have identified housing as a need during MFP enrollment will be eligible for MFP Pre-Tenancy Support for a period up to six months prior to transitioning

c. Inclusions

i. Teaching members how to satisfy the requirements of tenancy

ii. Teaching members their rights as tenants

iii. Teaching members compliance requirements for lease agreements

iv. Teaching members about tenancy sustaining practices

v. Completing lease applications and requesting rental accommodations

vi. Coordinating required documentation

vii. Teaching members how to make payments to landlords

viii. Teaching members how to schedule tours for prospective units

ix. Accessing other resources related to Pre-tenancy Support and household management

d. Exclusions

i. Pre-tenancy Support shall not be available to members following transition to the community

ii. Pre-Tenancy Support services will be limited to 52 units where 1 unit equals 15 minutes

1) Reimbursement for mileage, travel, or transportation

iii. Provider Requirements

1) Providers of MFP services must:

a) Abide by all the terms of their provider agreement with the Department; and

b) Not discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services

c) Comply with all applicable federal and state statutes, regulations, and guidance

e. Provider Reimbursement

i. Pre-Tenancy Support will be reimbursed up to 52 units where 1 unit equals 15 minutes

ii. The total amount will be prior authorized in the State's MMIS system and will be reimbursable upon delivery of service

iii. Requests for units above the authorized amount will be reviewed by designated State staff

iv. Reimbursement for MFP services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.

1) The statewide fee schedule for these services is reviewed annually and published in the provider billing manual.

2) Reimbursement for MFP services is also conditional upon:

a) The member's eligibility for MFP services;

b) The provider's certification status; and

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

3) Payments will be made by agencies designated by contract with the State to provide this service

4) Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

5. MFP Peer Mentorship

a. MFP Supplemental Service that offers support from providers with lived experience to better understand the transition process, how to navigate Colorado's Medicaid System and other community resources prior to transition. The goal of MFP Peer Mentorship is to connect members with other people who have transitioned to the community to build independence and reduce impacts of social isolation after leaving a long-term care facility.

b. Eligibility

i. MFP Peer Mentorship will be available to members for a period up to six months prior to transitioning who meet the following eligibility criteria:

c. Inclusions

i. MFP Peer Mentorship means support provided by peers of the member on matters of community living and may include:

1) Problem-solving issues drawing from shared experience

2) Goal setting, self-advocacy, community acclimation and techniques

3) Assisting with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups, and commissions

4) Activities that promote interaction with friends and companions of choice

5) Teaching and modeling of social skills, communication, group interaction, collaboration

6) Developing community relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests

7) Assisting the person in acquiring, retaining, and improving self-help, socialization, self-advocacy, and adaptive skills necessary for community living.

8) Support for integrated and meaningful engagement and awareness of opportunities for community involvement including volunteering, self- advocacy, education options, and other opportunities identified by the individual

9) Assisting members to be aware of and engage in community resources.

ii. Exclusions

1) MFP Peer Mentorship will not be available to members following transition to the community

2) Reimbursement for mileage, travel, or transportation

iii. Provider Requirements

1) MFP Peer Mentorship providers must meet requirements at Section 8.7535

2) Providers of MFP services must:

a) Conform to all state established standards for the specific services they provide under this program

b) Not discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services

c) Abide by all the terms of their provider agreement with the Department; and

3) Comply with all applicable federal and state statutes, regulations, and guidance

iv. Provider Reimbursement

1) MFP Peer Mentorship will be reimbursed up to 26 units where 1 unit equals 15 minutes

2) Requests for units above the authorized amount will be reviewed by designated State staff

3) The total amount will be prior authorized in the Department's MMIS system and will be reimbursable upon delivery of service

4) Reimbursement for MFP services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.

5) The statewide fee schedule for these services is reviewed annually and published in the provider billing manual.

6) Reimbursement for MFP services is also conditional upon:

a) The member's eligibility for MFP services

b) The provider's certification status

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

7) Payments will be made by agencies designated by contract with the State to provide this service

8) Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

6. Environmental Adaptations

a. MFP Supplemental Service that allows for modifications to a member's residence to be completed prior to transitioning where the modification represents a barrier that would otherwise prevent a member from discharging safely to the community. This support is differentiated from the existing home modification waiver benefit through the ability to initiate modifications to a member's home while they reside in a skilled setting. The TCA will work directly with the member to make referrals to Environmental Adaptation providers while the member resides in the facility planning for transition. The TCA will communicate with the HCBS case manager to ensure continuity with further home modifications under the HCBS Waiver following transition as warranted.

b. Eligibility

i. Members who have identified home accessibility as a need during MFP enrollment will be eligible for MFP Environmental Adaptations for a period up to six months prior to transitioning

c. Inclusions

i. Inclusions for Environmental Adaptations are outlined in Section 8.7524.

d. Exclusions

i. Exclusions for Environmental Adaptations are outlined in Section 8.7524.

e. Environmental Adaptations Oversight Responsibilities

i. The Environmental Adaptation (EA) Contractor shall consider alternative funding sources to complete the Environmental Adaptation These alternatives and the reason they are not available shall be documented in the case record.

1) The EA Contractor must confirm that the member is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by the Fair Housing Act.

ii. The EA Contractor may approve Environmental Adaptation projects estimated at less than $2,500 without Department approval, contingent on member authorization and confirmation of Environmental Adaptation fund availability.

iii. The EA Contractor shall obtain prior approval by submitting an Environmental Adaptation (EA) Request to the Department for Environmental Adaptation projects estimated at between $2,500 and $14,000.

1) The EA Contractor must submit the request and all supporting documentation according to Department prescribed processes and procedures. EA Requests submitted with improper documentation cannot be authorized.

2) The EA Contractor is responsible for retaining and tracking all documentation related to a member's Environmental Adaptation benefit and communicating that information to the member and EA Providers. The EA Contractor may request confirmation of a member's Environmental Adaptation history from the Department, its fiscal agent, or DOH.

iv. Environmental 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 member's needs and the therapeutic value of the requested Environmental Adaptation. When an OT/PT with experience in Environmental Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Environmental Adaptation would contribute to a member's ability to remain in or return to their home, and how the Environmental 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 EA Request.

2) The evaluation services may be provided by a home health agency or other qualified and approved OT/PT through Medicaid Home Health consistent with Home Health rules set forth in Section 8.520, including physician orders and plans of care.

a) The Transition Coordinator (TC) may initiate the OT/PT evaluation process before the member has been approved for waiver services, as long as the member is Medicaid eligible.

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

3) The EA Contractor and the OT/PT shall consider less expensive alternative methods of addressing the member's needs.

4) The EA Contractor shall solicit bids according to the following procedures:

a) The EA Contractor shall solicit bids from at least two Environmental Adaptation Providers.

i) The EA Contractor must verify that the provider is an enrolled Environmental Adaptation Provider.

ii) The bids must be submitted according to Department prescribed processes and procedures

b) The bids shall include a breakdown of the costs of the project including:

i) Description of the work to be completed.

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

iii) Estimate for building permits, if needed.

iv) Estimated timeline for completing the project.

v) Name, address and telephone number of the Environmental Adaptation Provider.

vi) Signature, including option for digital signature, of the Environmental Adaptation Provider.

vii) Signature, including option for digital signature, of the member or guardian or other indication of approval.

viii) Signature, including option for digital signature, of the homeowner or property manager if applicable.

c) Environmental Adaptation Providers have a maximum of ten (10) business days to submit a bid for the Environmental Adaptation project after the EA Contractor has solicited the bid.

i) If the EA Contractor has made three attempts to obtain a written bid from an Environmental Adaptation Provider and the Environmental Adaptation Provider has not responded within ten (10) business days, the EA Contractor may request approval of one bid. Documentation of the attempts shall be maintained by the EA Contractor.

d) The EA Contractor shall submit copies of the bid(s) and the OT/PT evaluation with the EA Request to the Department or its agent. The Department or its agent shall authorize the lowest bid that complies with the requirements of {Section 8.7524} and the recommendations of the OT/PT evaluation.

i) If a member or homeowner requests a bid that is not the lowest of the submitted bids, the EA Contractor shall request approval by submitting a written explanation with the EA Request.

e) A revised bid and Change Order request shall be submitted according to the procedures outlined in this section for any changes from the original EA Request according to Department prescribed processes and procedures.

v. If the member does not own a property to be modified, the EA Contractor shall obtain signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein. Signatures may be completed using a digital signature based on preference of the individual signing the form.

1) Written consent of the homeowner or property manager, as evidenced by the above-mentioned signatures, is required for all projects that involve permanent installation within the member's residence or installation or modification of any equipment in a common or exterior area.

2) If the member vacates the property, these signatures can be used as evidence that the homeowner or property manager agrees to allow the member to leave the modification in place or remove the modification as the member chooses. If the member chooses to remove the modification, the property must be left equivalent or better to its pre-modified condition. The homeowner or property manager may not hold any party responsible for removing all or part of an Environmental Adaptation project.

vi. If the EA Contractor does not comply with the process described above resulting in increased cost for an Environmental Adaptation, the Department may hold the EA Contractor financially liable for the increased cost.

vii. The Department or its agent may conduct on-site visits, or any other investigations deemed necessary prior to approving or denying the EA Request.

f. Environmental Adaptations Provider Requirements

i. An Environmental Adaptations Agency means a provider agency that has met all the standards for Home Modification and is an enrolled Medicaid provider.

ii. Provider Requirements for Environmental Adaptations are outlined in Section 8.7524.

iii. Providers of MFP services must

1) Conform to all state established standards for the specific services they provide under this program

2) Not discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services

3) Abide by all the terms of their provider agreement with the Department; and

4) Comply with all applicable federal and state statutes, regulations, and guidance

iv. Provider Reimbursement

1) Environmental Adaptations will be reimbursable up to a maximum cost of $14,000

2) Payment for Environmental Adaptations is outlined in Section 8.7524.

3) The total reimbursement will not exceed the total amount identified in the bid

4) Reimbursement for MFP services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.

a) The statewide fee schedule for these services is reviewed annually and published in the provider billing manual.

b) Reimbursement for MFP services is also conditional upon:

i) The member's eligibility for MFP services;

ii) The provider’s certification status; and

iii) The submission of invoices in accordance with proper billing procedures.

v. Payments will be made by agencies designated by contract with the State to provide this service

1) Payment for Environmental Adaptations does not offset the funding available to members under HCBS Home Modification benefits

vi. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department

8.555.4. MFP Case Management Functions

8.555.4.A Case Management Responsibilities

1. The case manager shall provide support in accordance with the functions outlined in Section 8.7206

8.555.4.B. Case Management Responsibilities – MFP Disenrollment

1. The case manager shall begin preparing members for dis-enrollment from the MFP program 90 days prior to the end of the member's MFP enrollment period and arrange for the continuation of HCBS services if the member continues to meet the eligibility requirements for a waiver listed at Section 8.7100

8.555.4.C. MFP Service Plan

1. The MFP Service Plan will be developed with input from the transition coordinator, staff from the discharging facility, the resident wanting to transition and others at the invitation of the member or guardian.

2. The transition assessment/plan, the member's level of functioning, service needs, available resources and potential funding resources will inform the development of the service plan.

3. The MFP Service Plan shall document that the member has been offered a choice:

    a. Between community-based services or institutional care;

    b. Between the MFP Program or a traditional HCBS Waiver;

    c. Among qualified and demonstration services; and

    d. Among qualified providers.

4. A new MFP Service Plan will be developed each time a member is reinstitutionalized and plans to return to a community setting. The MFP Service Plan shall address the reasons for the member's reinstitutionalization.

8.555.5 MFP SERVICE AUTHORIZATION

1. Determination for MFP services shall occur when all requirements defined in 8.555.2 have been met. Members will be identified in the State's prescribed case management system during the MFP referral screening. Once identified in the system, all services prior authorized for the member's care will be mapped to MFP funds in the State's MMIS system.

2. Transition Coordination services may be offered prior to the member's transition in preparation of the transition to a community setting.

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. Concentrator means an oxygen delivery system that operates electrically to concentrate oxygen from room air.

8.580.1.B. Hypoxemia means deficient oxygenation of blood.

8.580.1.C Nursing Facility means nursing facilities, intermediate nursing facilities, and skilled nursing facilities that receive facility payment reimbursement for care.

8.580.1.D. Oxygen Concentrator is the same as a concentrator.

8.580.1.E. Oxygen Delivery System means the method by which oxygen is delivered to the client.

8.580.1.F. 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.G. 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.H. 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.I. 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 Prescription

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.

a. Review and renewal of the prescription 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 was 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 review required every twelve months under this section, and the requirement for annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii), was suspended.

2. Suppliers must have a completed and current prescription 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 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 and prescriptions;

i. Oxygen therapy and oxygen equipment provided for Post Acute Oxygen Therapy of less than ninety days requires 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 (CRT) means a provider who meets all the requirements of Section 8.590.5.D. The following are terms defined in relation to CRT suppliers only, see Section 8.590.5.E.

1. Evaluation is when a supplier assesses the potential need for repair, replacement, and or modification. An evaluation may occur at the member's residence, supplier's facility, virtually, or other agreed upon location.

2. Order creation date is the date the evaluation is scheduled.

3. Repair fulfillment is when the repair has been completed, and any need for pick up or drop off equipment has occurred.

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. Licensed Practitioner means, for the purposes of Section 8.590, a physician, physician assistant, nurse practitioner, or clinical nurse specialist.

N. Medical Necessity, means for the purposes of Section 8.590, the definition as described at Section 8.076.1.8.

O. 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.

P. 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.

Q. 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.

R. 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.

S. 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.

T. 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.

U. 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.

V. 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.

W. 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. Medically Necessary; and

2. Prescribed by a 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 Section 8.590.4.L-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 Licensed Practitioner, and maintained by the provider as described at Section 8.590.4.E.7.

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, description of previous and 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 Licensed Practitioner's, primary care physician's and provider's name and identification numbers.

8. The serial numbers for all Wheelchair repairs.

9. The prescribing Licensed Practitioner's signature. The prescribing Licensed Practitioner shall 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 Licensed Practitioner's signature. The provider shall not complete or add information after the Licensed Practitioner 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. Licensed Practitioner prescriptions.

2. Approved prior authorization requests.

3. Additional documentation received from physicians or other licensed practitioners.

4. Documentation that the member or caregiver has been provided with the following:

a. Manufacturer's instructions.

b. Warranty information.

c. Registration documents.

d. Service manual.

e. Operating guides.

5. Documentation for 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 seven years.

8. Providers shall provide a copy of all documentation to a member or their 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.

8.590.5.E. Only Complex Rehabilitation (CRT) Suppliers must comply with this section for repair orders created on or after October 1, 2023. section per Colorado Revised Statute 25.5-5-323.

1. Beginning January 2024, the Department reports on CRT repair performance annually at the State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act hearing. The Department is to report on the metrics using the data received as outlined below.

2. The required metrics listed in Section 8.590.5.E.2 are to be reported by suppliers on all CRT repairs, including members also enrolled in Medicare coverage. Members with additional coverage other than Medicare, such as private insurance, are excluded from these reports.

    a. Quality of CRT repairs shall be reported to the Department using the data point in section 8.590.5.E.2.b.8.

        1. At the time the repair is fulfilled, regardless of the location, members will be asked to confirm that the equipment has been repaired to their satisfaction.

        2. Members, their legal guardian, or other authorized representative may be asked to confirm verbally or in writing, provided that the answers can be verified by a signature and date.

        3. This information may be obtained on a delivery ticket or as a separate form. This metric will be used to measure the number of repairs that were reported as satisfactory, not satisfactory, and where an answer was not obtained.

    b. Metrics must bereported using the following:

        1. Medicaid Identification Number.

        2. Type of equipment being repaired: Manual wheelchair, power wheelchair, non-wheelchair mobility device, other equipment.

        3. Does the member also have Medicare? Yes or no.

        4. Order creation date.

        5. Date of first available evaluation appointment (optional).

        6. Date evaluation occurred.

        7. Does the member have secondary/back up equipment? Yes or no.

        8. Quality of repair answer: Satisfactory, not satisfactory, or answer not obtained.

        9. Repair fulfillment date.

3. Suppliers of Complex Rehabilitation Technology are to follow the below requirements for reporting metrics to the Department.

a. Suppliers will prepare and send data listed above to the designated benefit inbox twice per calendar year, as outlined in the table below.

b. The deadlines represent the last day metrics will be accepted. Those that fall on a holiday or weekend are due before the end of the following business day.

Date of Repair Fulfillment	Deadline
December 1 - May 31	June 30
June 1 - November 31	December 31

b. Complex Rehabilitation Technology Suppliers will use their own template or software to maintain and submit the metrics for each applicable repair performed. Suppliers with multiple locations are required to compile the data for the entire company into one submission.

c. All Complex Rehabilitation Technology Suppliers will provide the required data points listed above and the Department will report on each supplier's performance as it relates to the metrics. The Department will maintain a record of the metrics received, including adherence to the reporting schedule. The Department may also request further information on the data provided either related to a batch of repairs, or repairs for a single member.

d. This information will be used to identify areas of potential improvement in the CRT repair industry and may be used in future stakeholder events, pursuant to Colorado Revised Statutes 25.5-5-323.

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. Compliance with this section is required as a condition of payment for DME requiring face-to-face encounters.

2. 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.

3. The face-to-face encounter must occur no more than six months before the DME is first provided to a member.

4. The face-to-face encounter must be conducted by one of the following practitioners:

   a. The Licensed Practitioner responsible for prescribing the DME;

   b. A nurse practitioner or clinical nurse specialist, working in collaboration with the prescribing Licensed Practitioner; or

   c. A physician assistant under the supervision of the prescribing Licensed Practitioner.

5. A practitioner may conduct a face-to-face encounter via telehealth or telemedicine if those services are covered by the Medical Assistance Program.

6. 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 Licensed Practitioner 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.

7. A Licensed Practitioner who prescribes DME requiring face-to-face encounters must document the following:

   a. That the face-to-face encounter was related to the primary reason the member required the prescribed DME;

   b. The name of the practitioner who performed the face-to-face encounter;

   c. The date of the face-to-face encounter; and

   d. That the face-to-face encounter occurred within the required timeframe.

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]