Department of Health Care Policy and Financing

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.7000 HOME AND COMMUNITY BASED SERVICES

10 CCR 2505-10 8.7000

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

8.7000 Home and Community-Based Services

8.7000.A Legal Authority

1. Authority

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

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

2. Scope and Purpose

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

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

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

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

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

3. Consequences for Non-Compliance

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

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

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

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

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

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

8.7001 Home and Community-Based Services Member Rights and Responsibilities

8.7001.A Definitions: Unless otherwise specified, the following definitions apply throughout Sections 8.7000-8.7600.

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

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

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

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

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

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

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

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

    b. If Covered HCBS are provided at a physical location to one or more individuals, the setting is considered an HCBS Setting, regardless of whether some individuals at the setting do not receive Covered HCBS. The requirements of Section 8.7001.B apply to the setting as a whole and protect the rights of all individuals receiving services at the setting regardless of payer source.

5. Informed Consent means the informed, freely given, written agreement of the individual (or, if authorized, their Guardian or other Legally Authorized Representative) to a Rights Modification. The Case Manager ensures that the agreement is informed, freely given, and in writing by confirming that the individual (or, if authorized, their Guardian or other Legally Authorized Representative) understands all of the information required to be documented in Section 8.7001.B.4 and has signed the Department-prescribed form to that effect.

6. Intensive Supervision means one-on-one (1:1), line-of-sight, or 24-hour supervision. Intensive Supervision is a Rights Modification if the individual verbally or non-verbally expresses that they do not want the supervision or if the supervision limits an individual's privacy, autonomy, access to the community, or other rights protected in Section 8.7001.B, because of the individual's challenging behavior(s).

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

    a. the Parent of a minor;

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

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

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

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

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

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

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

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

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

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

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

11. Person-Centered Support Plan means a service and support plan that is directed by the individual whenever possible, with the individual's representative acting in a participatory role as needed, is prepared by the Case Manager, identifies the supports needed for the individual to achieve personally identified goals, and is based on respecting and valuing individual preferences, strengths, and contributions.

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

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

13. Provider-Owned or -Controlled Non-Residential Setting means a physical location that is non-residential and that is owned, leased, operated, or managed by an HCBS Provider Agency or by an independent Contractor providing non-residential services.

a. Provider-Owned or -Controlled Non-Residential Settings include, but are not limited to, provider-owned facilities where Adult Day, Day Treatment, Specialized Habilitation, Supported Community Connections, Prevocational Services, Supported Employment Services, and Youth Day Services (including Youth Day Services at homes owned, leased, or operated by Provider Agencies/independent Contractors) are provided.

14. Provider-Owned or -Controlled Residential Setting means a physical location that is residential and that is owned, leased, operated, or managed by an HCBS Provider Agency or by an independent Contractor providing residential services.

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

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

15. Restraint means any manual method or direct bodily contact or force, physical or mechanical device, material, or equipment that restricts normal functioning or movement of all or any portion of a person's body, or any drug, medication, or other chemical that restricts a person's behavior or restricts normal functioning or movement of all or any portion of their body. Physical or hand-over-hand assistance is a Restraint if the individual verbally or non-verbally expresses that they do not want the assistance or if the assistance limits an individual’s autonomy or other rights protected in Section 8.7001.B.

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

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

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

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

        ii. the use of Restraints;

        iii. the use of Restrictive or Controlled Egress Measures;

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

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

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

        vi.

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

    c. For children under age 18, a limitation or restriction to any of the rights in Sections 8.7001.B.2 and 8.7001.B.3 that is typical for children of that age, including children not receiving HCBS, is not a Rights Modification. Consider age-appropriate behavior when assessing what is typical for children of that age. If the child is not able to fully exercise the right because of their age, then there is no need to pursue the Rights Modification process under Section 8.7001.B.4. However, if the proposed limitation or restriction is above and beyond what a typically developing peer would require, then it must be handled as a Rights Modification under Section 8.7001.B.4.

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

1. Statement of Purpose, Scope, and Enforcement

a. The purpose of this Section 8.7001.B is to implement the requirements of the federal Home and Community-Based Services (HCBS) Settings Final Rule, 79 Fed. Reg. 2947 (2014), codified at 42 C.F.R. § 441.301(c)(4). These rules identify individual rights that are protected at settings where people live or receive HCBS. They also set out a process for modifying these rights as warranted in individual cases. These rules apply to all HCBS under all authorities, except where otherwise noted.

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

2. Basic Criteria Applicable to All HCBS Settings

a. All HCBS Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as indicated in their Person-Centered Support Plan, subject to the Rights Modification process in Section 8.7001.B.4:

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

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

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

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

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

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

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

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

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

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

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

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

i) Document the request or representative payee designation;

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

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

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

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

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

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

a) The use of cameras, audio monitors, chimes, and alerts in (a) interior areas of residential settings, including common areas as well as bathrooms and bedrooms, and in (b) typically private areas of non-residential settings, including bathrooms and changing rooms, is acceptable only under the standards for modifying rights on an individualized basis pursuant to Section 8.7001.B.4.

b) If an individualized Assessment indicates that the use of a camera, audio monitor, chime, or alert in the areas identified in the preceding paragraph is necessary for an individual, this modification must be reflected in their Person-Centered Support Plan. The Person-Centered Support Plans of other individuals at that setting must reflect that they have been informed in Plain Language of the camera(s)/monitor(s)/chime(s)/alert(s) and any methods in place to mitigate the impact on their privacy. The provider must ensure that only

appropriate staff/Contractors have access to the camera(s)/monitor(s)/chime(s)/alert(s) and any recordings and files they generate, and it must have a method for secure disposal or destruction of any recordings and files after a reasonable period.

c) Cameras, audio monitors, chimes, and alerts on staff-only desks and exterior areas, cameras on the exterior sides of entrances/exits, and cameras typically found in integrated employment settings, generally do not raise privacy concerns, so long as their use is similar to that practiced at non-HCBS Settings. In Provider-Owned or -Controlled Settings, notice must be provided to all individuals that they may be on camera and specify where the cameras are located. If such devices have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to the Rights Modification requirements of Section 8.7001.B.4.

d) Audio monitors, chimes, motion-activated bells, silent or auditory alarms, and alerts on entrances/exits at residential settings have the effect of restricting or controlling egress and are subject to the Rights Modification requirements of Section 8.7001.B.4. If such devices on entrances/exits at non-residential settings have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to the Rights Modification requirements of Section 8.7001.B.4.

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

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

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

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

vii. Each individual is afforded the opportunity to:

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

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

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

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

5) Be free from physical abuse and inhumane treatment;

6) Be protected from all forms of sexual exploitation;

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

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

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

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

ix. Nothing in this rule shall be construed to interfere with the ability of a Guardian or other Legally Authorized Representative to make decisions within the scope of their guardianship order or other authorizing document.

3. Additional Criteria for HCBS Settings

a. Provider-Owned or -Controlled Residential Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as indicated in their Person-Centered

Support Plan, subject to the Rights Modification process in Section 8.7001.B.4:

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

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

a) Provide substantially the same terms for all individuals;

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

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

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

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

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

g) Specify the duration of the agreement;

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

i) Specify expectations for maintenance;

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

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

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

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

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

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

3) The lease, residency agreement, or other written agreement may not modify the individual rights protected under Sections 8.7001.B.2 and 8.7001.B.3, such as (a) by imposing individualized terms that modify these conditions or (b) by requiring individuals to comply with house rules or resident handbooks that modify everyone's rights.

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

5) A violation of a lease or residency agreement, a change in the resident's medical condition, or any other development that leads to a notice to leave must include at least 30 calendar days' notice to the individual (or, if authorized, their Guardian or other Legally Authorized Representative).

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

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

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

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

1) Individuals must have a key or key code to their home, a bedroom door with a lock and key, lockable bathroom doors, privacy in changing areas, and a lockable place for belongings, with only appropriate staff/Contractors having keys to such doors and locks. Staff/Contractors must knock and obtain permission before entering individual units, bedrooms, bathrooms, and changing areas. Staff/Contractors may use keys to enter these areas and to open private storage spaces only under limited circumstances agreed upon with the individual. If an individual's lockable place for their belongings is a locker, the Provider Agency must supply a padlock and key/combination.

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

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

iii. The Residential Setting does not have institutional features not found in a typical home, such as staff uniforms; entryways

containing staff postings or messages; or labels on drawers, cupboards, or bedrooms for staff convenience.

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

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

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

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

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

b. Other Residential Settings in which one or more individuals receiving 24-hour residential services and supports reside must have all of the qualities of and protect all of the same individual rights as Provider-Owned or -Controlled Residential Settings, as listed above, other than Subsection 8.7001.B.3.a.i relating to a lease or other written agreement providing protections against eviction, subject to the Rights Modification process in Section 8.7001.B.4.

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

i. This group of settings includes, but is not limited to, homes in which no individual receives Individual Residential Service and Supports (IRSS) and one or more individuals receive Consumer-Directed Attendant Support Services (CDASS), Health Maintenance

Services, Homemaker Services, In-Home Support Services (IHSS), and/or Personal Care Services.

d. Provider-Owned or -Controlled Non-Residential Settings must have all of the qualities of and protect all of the same individual rights as Provider-Owned or -Controlled Residential Settings, as listed above, other than Subsection 8.7001.B.3.a.i relating to a lease or other written agreement providing protections against eviction and Subsection 8.7001.B.3.a.ii relating to privacy in one's living/sleeping unit, subject to the Rights Modification process in Section 8.7001.B.4.

i. Provider-Owned or -Controlled Non-Residential Settings must afford individuals privacy in bathrooms and changing areas and a lockable place for belongings, with only the individuals and appropriate staff/Contractors having keys to such doors and locks. In addition to supplying a locker, the Provider Agency must supply a padlock and key/combination.

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

e. Other Non-Residential Settings must have all of the qualities of and protect the same individual rights as Provider-Owned or -Controlled Non-Residential Settings, as stated immediately above, to the same extent for HCBS participants as they do for other individuals, subject to the Rights Modification process in Section 8.7001.B.4.

4. Rights Modifications

a. Any modification of an individual's rights must be supported by a specific assessed need and justified in the Person-Centered Support Plan, pursuant to the process set out in Sections 8.7001.B.4.c and 8.7001.B.4.d below. Rights Modifications may not be imposed across-the-board and may not be based on the convenience of the Provider Agency/its independent Contractor. The Provider Agency/its independent Contractor must ensure that a Rights Modification does not infringe on the rights of individuals not subject to the modification. Wherever possible, Rights Modifications should be avoided or minimized, consistent with the concept of dignity of risk.

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

c. For a Rights Modification to be implemented, the following information must be documented in the individual's Person-Centered Support Plan,

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

i. The right to be modified.

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

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

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

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

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

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

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

ix. An assurance that interventions and supports will cause no harm to the individual, including documentation of the implications of the

modification for the individual's everyday life and the ways the modification is paired with additional supports or other approaches to prevent harm or discomfort and to mitigate any effects of the modification.

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

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

d. Additional Rights Modification process requirements:

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

ii. Any Provider Agencies that desire or expect to be involved in implementing a Rights Modification may supply to the Case Manager information required to be documented under this Section 8.7001.B.4, except for documentation of Informed Consent and the offers and response relating to an advocate, which may be obtained and documented only by the Case Manager. The individual determines whether any information supplied by the Provider Agency is satisfactory before the Case Manager enters it into their Person-Centered Support Plan.

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

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

1) Such review shall include the original reason for modification, current circumstances, success or failure of

programmatic intervention, and the need for continued modification.

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

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

v. At the time a right is modified, such action if subject to Human Rights Committee review shall be referred to the Human Rights Committee for review and recommendation. Such review shall include an opportunity for the individual or Member who is affected, Parent of a minor, Guardian or other Legally Authorized Representative, after being given reasonable notice of the meeting, to present relevant information to the Human Rights Committee.

e. Use of Restraints

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

g. If there is a serious risk to anyone's health or safety, a Rights Modification may be implemented or continued for a short time without meeting all the requirements of this Section 8.7001.B.4, so long as the Provider Agency/its independent Contractor immediately (a) implements staffing and other measures to deescalate the situation and (b) reaches out to the Case Manager to set up a meeting as soon as possible, and in no event past the end of the third business day following the date on which the risk arises. At the meeting, the individual can grant or deny their Informed Consent to the Rights Modification. The Rights Modification may not be continued past the conclusion of this meeting or the end of the third business day, whichever comes first, unless all the requirements of this Section 8.7001.B.4 have been met.

h. When a Provider Agency proposes a Rights Modification and supplies to the Case Manager the unsigned Informed Consent form with all of the information required to be documented under this Section 8.7001.B.4, except for documentation that may be obtained only by the Case Manager, the Case Manager shall arrange for a meeting with the individual to discuss the proposal and facilitate the individual's decision regarding whether to grant or deny their Informed Consent. Except when the timeline in Section 8.7001.B.4.g applies, the Case Manager shall arrange for this meeting to occur by the end of the tenth business day following the date on which they received from the Provider Agency all of the required information. The individual may elect to make a final decision during or after this meeting. If the individual does not inform their Case Manager of their decision by the end of the fifth business day following the date of the meeting, they are deemed not to have consented.

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

1. Member and Other Individual Rights

a. An individual receiving services has the same legal rights and responsibilities guaranteed to all other individuals under the federal and state constitutions and federal and state laws including, but not limited to, those contained in Sections 25.5-10-201 through 240, C.R.S., unless such rights are modified pursuant to state or federal law. Many rights of Members and other individuals and a process for modifying those rights in individual cases are set forth in Section 8.7001.B. Members and other individuals have additional rights as set forth below and elsewhere in these rules. These additional rights apply not just at HCBS Settings, but also in the context of Case Management, and unless otherwise specified, they are not subject to modification.

b. Every person has the right to receive the same consideration and treatment as anyone else regardless of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

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

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

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

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

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

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

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

j. Members shall have the right to read or have explained any rules or regulations adopted by the Department and policies and procedures of the Case Management Agency pertaining to such people's activities and services and supports, and to obtain copies of Sections 25.5-10-201 through 240, C.R.S., rules, policies or procedures at no cost or at a reasonable cost in accordance with Section 24-72-205, C.R.S.

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

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

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

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

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

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

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

2. Case Management Requirement for Preservation of Member Rights

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

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

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

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

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

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

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

4. Member Responsibilities

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

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

ii. Assist in promoting the individual’s independence,

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

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

1) Level of Care Screen;

2) Needs Assessment;

3) Person-Centered Support Planning;

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

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

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

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

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

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

4) There are problems with receiving HCBS Waiver Services,

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

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

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

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

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

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

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

8.7100 Waiver/Program Eligibility Requirements

8.7100.A Definitions

Unless otherwise specified, the following definitions apply throughout Section 8.7000-8.7500.

1. Activities of Daily Living means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs, and memory and cognition.

2. Agency means any public or private entity operating in a for-profit or nonprofit capacity, with a defined administrative and organizational structure. At Health Care Policy and Financing’s discretion, any sub-unit of the Agency that is not geographically close enough to share administration and supervision on a frequent and adequate basis shall be considered a separate Agency for purposes of certification and contracts.

3. Applicant means an individual or Member who is seeking a Long-Term Services and Supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an Assessment.

4. Assessment is as defined at Section 8.7200.B.1

5. BBA Working Disabled Group is as defined at 42 U.S.C § 1396a(a)(10)(A)(ii)(XIII)).

6. Brain Injury means an injury to the brain of traumatic or acquired origin that results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of Assessment:

   a. Nonpsychotic mental disorders due to brain damage; or

b. Anoxic brain damage; or

c. Compression of the brain; or

d. Toxic encephalopathy; or

e. Subarachnoid and/or intracerebral hemorrhage; or

f. Occlusion and stenosis of precerebral arteries; or

g. Acute, but ill-defined cerebrovascular disease; or

h. Other and ill-defined cerebrovascular disease; or

i. Late effects of cerebrovascular disease; or

j. Fracture of the skull or face; or

k. Concussion resulting in an ongoing need for assistance with Activities of Daily Living; or

l. Cerebral laceration and contusion; or

m. Subarachnoid, subdural, and extradural hemorrhage, following injury; or

n. Other unspecified intracranial hemorrhage following injury; or

o. Intracranial injury; or

p. Late effects of musculoskeletal and connective tissue injuries; or

q. Late effects of injuries to the nervous system; or

r. Unspecified injuries to the head resulting in an ongoing need for assistance with Activities of Daily Living.

7. Case Management is as defined at Section 25.5-6-1701 C.R.S including the calculation of Member payment.

8. Case Management Agency (CMA) 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 (HCBS) waivers.

9. Member is as defined in 8.7001.A.8-B.

10. Complex Behavior means behavior that occurs related to a diagnosis by a licensed physician, psychiatrist, or psychologist that includes one or more

substantial disorders of the cognitive, volitional, or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior.

11. Complex Medical Needs means needs that occur as a result of a chronic medical condition diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12) months, requires skilled care, and that without intervention may result in a severely life-altering condition.

12. Congregate Facility means a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services, and social care but do not require regular twenty-four hour medical or nursing care.

13. Uncertified Congregate Facility means a facility as defined at Section 8.7100.A.12 that is not certified as an Alternative Care Facility.

14. Continued Stay Review means a re-assessment conducted by a Case Management Agency as defined in Section 8.7202.F.

15. Comprehensive Review of the Person's Life Situation means a thorough review of all aspects of the person's current life situation by the Provider Agency in conjunction with other Members of the Member Identified Team.

16. Corrective Action Plan is as defined at Section 8.7200.B.11

17. Cost Containment means the same as Provisions for Compliance with Federal Cost Effectiveness at 8.7100.A.52-A.

18. Crisis means an event, series of events, and/or state of being of greater than normal severity for the Member and/or Family that is outside the manageable range for the Member or their Family and poses a danger to self, family, and/or the community. Crisis may be self-identified, family- identified, and/or identified by an outside party.

19. Deinstitutionalized means transferred from institutional care to community-based care.

20. Diverted means maintained in institutional care.

21. Developmental Delay means one or more of the following:

    a. A child less than five years of age who is at risk of having a Developmental Disability because of the presence of one or more of the following measurements as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures:

        i. Chromosomal conditions associated with delays in development,

ii. Congenital syndromes and conditions associated with delays in development,

iii. Sensory impairments associated with delays in development,

iv. Metabolic disorders associated with delays in development,

v. Prenatal and perinatal infections and significant medical problems associated with delays in development,

vi. Low birth weight infants weighing less than 1200 grams, or

vii. Postnatal acquired problems resulting in delays in development.

b. A child under five years of age who has the equivalence of twenty-five percent (25%) or greater delay in one or more of the five domains of development when compared with chronological age; or equivalence of 1.5 standard deviations or more below the mean in one or more of the five domains of development as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures. The five domains are:

i. Adaptive development;

ii. Cognitive development;

iii. Communication development;

iv. Physical development, including vision and hearing; and,

v. Social or emotional development.

c. A child under three years of age who lives with one or both Parents who have been determined to have a Developmental Disability by a Case Management Agency.

22. Developmental Disabilities Professional means a person who has a bachelor's degree and a minimum of two years' experience in the field of Developmental Disabilities or a person with at least five years of experience in the field of Developmental Disabilities with competency in the following areas:

a. Understanding of civil, legal, and human rights;

b. Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies; and

c. Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.

23. Developmental Disability means a disability that:

    a. Is manifested before the person reaches 22 years of age;

    b. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria below at Subsections 8.7100.A.23.c.i and/or 8.7100.A.23.c.ii; and,

    c. Is attributable to an Intellectual and Developmental Disability or related conditions which include Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an Intellectual and Developmental Disability. Unless otherwise specifically stated, the federal definition of "developmental disability" at 42 U.S.C. § 15002(8) shall not apply.

        i. Impairment of general intellectual functioning means that the person has been determined to have a full-scale intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15).

            1) A secondary score comparable to the General Abilities Index for a Wechsler Intelligence Scale that is two or more standard deviations below the mean may be used only if a full-scale score cannot be appropriately derived.

            2) Score shall be determined using a norm-referenced, standardized test of general intellectual functioning comparable to a comprehensively administered Wechsler Intelligence Scale or Stanford-Binet Intelligence Scales, as revised or current to the date of administration. The test shall be administered by a licensed psychologist or a school psychologist.

            3) When determining the intellectual quotient equivalent score, a maximum confidence level of ninety percent (90%) shall be applied to the full-scale score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the Applicant being determined to have a Developmental Disability.

        ii. Adaptive behavior similar to that of a person with intellectual disability means an overall adaptive behavior composite or equivalent score that is two or more standard deviations below the mean.

1) Measurements shall be determined using a norm-referenced, standardized Assessment of adaptive behaviors that is appropriate to the person's living environment and comparable to a comprehensively administered Vineland Scale of Adaptive Behavior, as revised or current to the date of administration. The Assessment shall be administered and determined by a professional qualified to administer the Assessment.

2) When determining the overall adaptive behavior score, a maximum confidence level of ninety percent (90%) shall be applied to the overall adaptive behavior score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the Applicant being determined to have a Developmental Disability.

d. A person shall not be determined to have a Developmental Disability if it can be demonstrated such conditions are attributable to only a physical or sensory impairment or a mental illness.

24. Early and Periodic Screening Diagnosis and Treatment (EPSDT) is as defined in Section 8.280.1.

25. Extraordinary Needs means Complex Behavior and/or Medical Support Needs that, without care provided in a residential childcare facility, would place a child at risk of unwarranted child welfare involvement or other system involvement.

26. Extreme Safety Risk to Self means a factor in addition to specific Support Level scores that are considered in the calculation of a Member's Support Level. This factor shall be identified when a Member:

a. Displays self-destructiveness related to self-injury, suicide attempts, or other similar behaviors that seriously threaten the Member's safety; and,

b. Has a Rights Modification in accordance with Sections 8.7001 or 8.7001.B.4 or has a court order that imposes line of sight supervision unless the Member is in a controlled environment that limits the ability of the Member himself or herself.

27. Family as used in rules pertaining to support services and the Family Support Services Program means a group of interdependent persons residing in the same household that consists of a Family Member with a Developmental Disability or a child under the age of five years with a Developmental Delay, and one or more of the following:

a. A mother, father, brother(s), sister(s) or any combination; or,

b. Extended blood relatives such as grandparent(s), aunt(s) or uncle(s); or,

c. An adoptive Parent(s); or,

d. One or more persons to whom legal custody of a person with a Developmental Disability has been given by a court; or

e. A spouse and/or their children.

28. Financial Eligibility means eligibility based on the individual's financial circumstances, including income and resources.

29. Functional Eligibility means eligibility based on the criteria for Long-Term Services and Supports as determined by the Department's prescribed Assessment instrument, the Long-Term Services and Supports Level of Care Eligibility Determination Screen.

30. Functional Needs Assessment means a comprehensive, in-person evaluation using the Long-Term Services and Supports Level of Care Eligibility Determination Screen and medical verification provided using the Professional Medical Information Page to determine if the individual meets the institutional Level of Care (LOC).

31. Group Residential Services and Supports (GRSS) means residential habilitation provided in group living environments of four to eight Members receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment as a residential care facility or residential community home for persons with Developmental Disabilities.

32. Grievance means the formal expression of a Complaint.

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

34. Guardian Ad Litem means a person appointed by a court to act in the best interests of a child involved in a proceeding pursuant to Title 19, Article 3, C.R.S., or the "School Attendance Law of 1963," set forth in Title 22, Article 33, C.R.S.

35. Home and Community-Based Services (HCBS) waiver means services and supports authorized by a waiver granted pursuant to 42 U.S.C. 1396n(c) of 1935 (the Act) and provided in community settings to a Member who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

36. Hospital Level of Care is as defined at 42 CFR §440.10.

37. Inability for Independent Ambulation means (1) the individual does not walk, and requires the use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own, or (2) the individual does walk, but requires the use of a walker or cane in all settings, whether or not they can use the walker or cane safely, on their own, or (3) the individual does walk but requires “touch” or “stand-by” assistance to ambulate safely in all settings.

38. Increased Risk Factors means situations or events that occur at a certain frequency or pattern historically that have led to Crisis.

39. Institution means a hospital, nursing facility, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) for which the Department makes Medicaid payment under the Medicaid State Plan.

40. Intellectual and Developmental Disability means a disability that manifests before the person reaches 22 years of age, that constitutes a substantial disability to the affected person, and that is attributable to an Intellectual and Developmental Disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an Intellectual and Developmental Disability. Unless otherwise specifically stated, the federal definition of “developmental disability” found in 42 U.S.C. sec. 15001 et seq., does not apply.

    a. Impairment of general intellectual functioning means the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. When an individual's general intellectual functioning cannot be measured by a standardized instrument, then the Assessment of a qualified professional shall be used.

    b. Adaptive behavior similar to that of a person with Intellectual and Developmental Disabilities means the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's Substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

41. Substantial intellectual deficit(s) means an intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

42. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) means a publicly or privately operated facility that provides health and habilitation services to a Member with an intellectual or Developmental Disability or related conditions.

43. Level of Care (LOC) means the specified minimum amount of assistance a Member must require to receive services in an institutional setting under the Medicaid State Plan.

44. Level of Care Assessment means a comprehensive evaluation with the Individual seeking services and others chosen by the Individual to participate, conducted by the Case Manager utilizing the Department's prescribed Assessment instrument, Long-Term Services and Supports Level of Care Eligibility Determination Screen, with supporting diagnostic information from the Individual's medical providers, to determine the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports programs.

45. Level of Care Screen means an Assessment conducted in accordance with Section 8.7202.E.

45-B. Licensed Mental Health Professional means a mental health provider who possesses one or more of the following Colorado licenses: Psychologist, Psychiatrist, or other licensed mental health professional. All licenses shall be active and in good standing.

46. Life-Limiting Illness means a medical condition or set of medical conditions that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood at age 19. A Life-Limiting Illness means a medical condition or set of condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood. Conditions that are incurable, irreversible, and that usually result in death are considered as one criterion for eligibility for the HCBS-CwCHN waiver.

47. 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.

48. Medicaid Eligible means an individual meets the criteria for Medicaid benefits based on the individual's financial determination and disability determination when applicable.

49. Nursing Facility Level of Care is as defined at 42 CFR §440.40.

50. Parent means the biological or adoptive Parent.

51. Professional Medical Information Page (PMIP) means the medical information form signed by a Licensed Medical Professional used to certify Level of Care.

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

52-A. Provisions for Compliance with Federal Cost Effectiveness means the person centered and needs based assessed approach in which HCBS waiver services are approved. They ensure HCBS waiver services are not duplicative, are based on assessed need of the member seeking services, and that services are the most economical and reliable means to meet an identified need of a member.

53. Extreme Safety Risk to Others means a factor in addition to specific Support Level scores that are considered in the calculation of a Member's Support Level. This factor shall be identified when a Member has:

    a. A significant challenging behavior that poses a current and serious safety risk to others, involving harm to another person including arson, and poses a risk of repeating similar serious action; and has either,

    b. A Rights Modification in accordance with Section 8.7001 that imposes line of sight supervision unless the Member is in a controlled environment; or,

    c. A court order, parole and/or probation that imposes line of sight supervision unless the Member is in a controlled environment that limits their ability to engage in the behaviors that pose a serious risk or to leave the controlled environment unsupervised.

54. Public Safety Risk-Not Convicted means a factor in addition to specific Support Intensity Scale scores that is considered in the calculation of a Member's Support Level. This factor shall be identified when a Member has:

    a. Not been found guilty through the criminal justice system, but does pose a current and serious risk of committing actions involving harm to another person or arson; and,

    b. A Rights Modification in accordance with Section 8.7001 or through parole or probation, or a court order that imposes line of sight supervision unless the Member is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

55. Reassessment means a periodic reevaluation according to the requirements at Section 8.7200.B.27.

56. Referral means any notice or information (written, verbal, or otherwise) presented to a Case Management Agency that indicates that a person may be appropriate for services or supports provided through the disabilities system and for which the Case Management Agency determines that some type of follow-up activity for eligibility is warranted.

57. Respondent means a person participating in the Support Intensity Scale Assessment who has known the Member for at least three months and has knowledge of the Member and their abilities. The Respondent must have recently observed the Member in one or more places such as home, work, or in the community.

58. Request for Developmental Disability Determination means written document, either handwritten or a signed standardized form, which is submitted to a Case Management Agency requesting that a determination of Developmental Disability be completed.

    a. Screening for Early Intervention Services means a preliminary review of how a child is developing and learning in comparison to other similarly situated children for the purpose of determining if early intervention services are medically necessary.

59. Seclusion means the placement of a Member alone in a closed room for the purpose of punishment. Seclusion for any purpose is prohibited.

59-B. Serious Emotional Disturbances (SED) means a mental, behavioral or emotional disorder that meets these criteria:

    a. Has been diagnosed by a Licensed Mental Health Professiona according to criteria set forth in the current Diagnostic and Statistical Manual of Mental Disorders; the DC:0–5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; or the International Classification of Diseases,

    b. Has functional impairments, which interferes with the Member’s functioning in family, social relationships, school or community, and

    c. Which have caused the Member to experience an emotional disturbance within the past 12 months for children aged 6 and older or the past 3 months for children aged 5 and younger, prior to application on a continuous or intermittent basis, as determined and documented by a Licensed Mental Health Professional.

d. SED shall not include substance-related disorders, or primary conditions or problems classified in the DSM as other conditions that may be a focus of clinical attention.

60. Support Intensity Scale Interviewer means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department-approved trainer using the Department-approved curriculum. Support Intensity Scale Interviewers must maintain a standard for conducting Support Intensity Scale Assessments as measured through periodic interviewer reliability reviews.

61. Support means any task performed for the Member where learning is secondary or incidental to the task itself or an adaptation is provided.

62. Supports Intensity Scale (SIS) means the standardized Assessment tool that gathers information from a semi-structured interview of Respondents who know the Member well. It is designed to identify and measure the practical support requirements of adults with Developmental Disabilities.

63. Support Level means a numeric value determined using an algorithm that places Members into groups with other Members who have similar overall support needs.

63-A. Target Group Criteria means the factors that define a specific population to be served through an HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic conditions, age, or diagnosis, and may include other criteria such as demonstrating an exceptional need.

64. TWWIIA Basic Coverage Group comprise working individuals who are at least 16 but less than 65 years of age who, except for their income and resource levels, are eligible to receive Supplemental Security Income (SSI).

65. Three Hundred Percent (300%) Eligible persons mean those:

a. Whose income does not exceed 300% of the SSI benefit level,

b. Who, except for the level of their income, would be eligible for an SSI payment, and

c. Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for one calendar month.

66. Utilization Review Contractor (URC) means the Agency contracted with the Department to review the HCBS waiver applications for determination of eligibility based on the additional targeting criteria.

67. Utilization Review means a review conducting for the purpose of approving or denying admission or continued stay in the waiver based on Level of Care needs, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures, or settings.

68. Waiver Services means optional services defined in the current federally approved HCBS waiver documents and does not include Medicaid State Plan benefits.

8.7100.B Eligible Persons

1. HCBS Waiver Services shall be offered to persons who meet all the eligibility requirements below provided the individual can be served within the capacity limits in the federal waiver. The HCBS waivers:

    a. Shall not constitute an entitlement to services from the Department,

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

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

    d. May limit the individual waiver program's enrollment when utilization of the HCBS waiver program is projected to exceed legislative spending authority.

2. The section hereby incorporates terms and provisions of the federally approved HCBS waivers. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver(s) shall control.

8.7100.C Financial Eligibility

1. Members shall meet the Medicaid Assistance eligibility criteria for Long Term Care as stated at Section 8.100.

2. The Applicant's income must be less than 300% of the current Supplemental Security Income Federal Benefit Rate and countable resources less than $2,000 for a single person or $3,000 for a couple.

3. Spousal impoverishment rules set forth at § 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special HCBS waiver group. In the case of a participant with a community spouse, the state shall use spousal post-eligibility rules as set forth at §1924 of the Act. Spousal impoverishment rules do not apply to people in the Medicaid Buy-In program.

4. The HCBS waiver programs provide services both for individuals eligible only for Medicaid and for individuals who are dually eligible for both Medicare and Medicaid.

    a. Individuals may be eligible to participate in the adult HCBS waiver programs through the Medicaid Buy-in Program for Working Adults with Disabilities if all listed eligibility criteria listed at 8.100.6.P are met.

8.7100.D Level of Care and Target Group

1. Individuals shall be referred to the Case Management Agency for an initial HCBS eligibility determination. The Long-Term Services and Supports Level of Care (LOC) eligibility determination screen is used to determine an individual's need for institutional Level of Care.

2. The state-prescribed Assessment instrument shall measure six defined Activities of Daily Living (ADLs) and the need for supervision for behavioral, executive or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating.

3. Level of Care Assessments and Reassessments shall be performed by Case Management Agencies and utilize the same instrument in determining the Level of Care for the waiver as for State Plan institutional care.

4. The individual also must be at risk of placement in an Institution within one month, but for the availability of Waiver Services. See individual waiver program for specific Level of Care requirements.

5. For initial Level of Care eligibility determinations, the Professional Medical Information Page (PMIP) shall be completed by a treating medical professional who verifies the individual’s qualifying diagnoses or conditions. .

6. The individual must require Long-Term Services and Supports to remain in their own home, in the Family residence, or in the community.

7. To utilize HCBS Waiver Benefits, the individual must choose to receive services in their home or community.

8. The cost of HCBS Waiver Services shall not be greater than the cost of placement in an Institution and the individual’s safety and health can be assured in the community within the federally approved capacity and the aggregate cost containments of the enrolled waiver program.

9. The Case Management Agency shall certify HCBS waiver eligibility only for those individuals:

a. Determined by the Case Management Agency to meet the target group designation for one or more waiver programs detailed in the Target Group Criteria section of each HCBS waiver program at Section 8.7101.

b. Determined by a Level of Care Assessment to require the Level of Care available in an Institution according to Section 8.401; or

c. A length of stay shall be assigned by the Case Management Agency for approved admissions according to guidelines at Section 8.402.

8.7100.E Receiving HCBS Waiver Services

1. Only Members who receive HCBS Waiver Services as defined at Section 8.7500, or who have agreed to accept HCBS services when eligibility criteria have been met are eligible for an HCBS waiver program.

   a. Case Management is not a waiver service and shall not be used to satisfy this requirement.

   b. Desire or need for home health services or other Medicaid State Plan services that are not identified as HCBS Waiver Services shall not satisfy this eligibility requirement.

2. HCBS waiver program Members who have received no HCBS Waiver Services for one calendar month shall be discontinued from the program.

3. Members may not be simultaneously enrolled in more than one HCBS waiver.

8.7100.F Institutional Status

1. Members who are residents of Institutions are not eligible for HCBS Waiver Services while residing in such Institutions.

2. A Member enrolled in an HCBS waiver and who is admitted to a hospital may not receive HCBS Waiver Services while residing in the hospital. If the Member resides in the hospital for a continuous period of one month or more, the Case Manager shall terminate the Member from the HCBS waiver program.

3. A Member enrolled in an HCBS waiver and who is admitted to a nursing facility or ICF-IID may not receive HCBS Waiver Services while in the nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities, except as provided below:

   a. If Medicaid pays for all or part of the nursing facility care or Intermediate Care Facilities for Individuals with Intellectual Disabilities, or if the Case Manager verifies that a Long-Term Services and Supports Level of Care Eligibility Determination Screen has been completed for the nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities

placement, the Case Manager must terminate the Member from the HCBS waiver program.

b. A Member enrolled in an HCBS waiver who enters a nursing facility for HCBS respite care shall not be required to obtain a Long-Term Services and Supports Level of Care Eligibility Determination Screen and shall not be terminated from the HCBS waiver program.

c. Nothing in this section is intended to create a right to receive respite care services pursuant to the Waiver Benefit if respite care services are not included in the waiver.

8.7100.G Provisions for Compliance with Federal Cost Effectiveness

1. The Department of Health Care Policy and Financing shall conduct periodic aggregate cost effectiveness analyses per federal requirements and in partnership with the Centers for Medicare and Medicaid.

8.7100.H Maintenance of HCBS Waiver Eligibility

1. The Member shall maintain eligibility by meeting General Eligibility and waiver program-specific requirements set forth herein subject to the following:

   a. Reevaluation of the Member to verify Medicaid, financial, and program eligibility is required within twelve months following any previous Assessment. The Continued Stay Review will follow the same procedures set forth at Section 8.401.11-.17(H).

   b. The Member must receive at least one HCBS waiver service each calendar month.

   c. The Member must not be simultaneously enrolled in any other HCBS waiver program.

   d. The Member must not be residing in an Institution, correctional facility, or other Institution.

8.7100.I Waiting List

1. Individuals who are determined eligible for a HCBS Waiver Services, who cannot be served within the capacity limits of the federally-approved waiver, shall be eligible for placement on the waiting list for a HCBS waiver for which they applied. A separate waiting list shall be maintained for each waiver.

   a. The Department shall maintain the waiting list.

   b. The date of initial determination of eligibility for an HCBS waiver shall determine the individual’s position on the waiting list.

c. As openings become available within the capacity limits of the federal waiver, individuals shall be considered for services based on the criteria in order of priority as follows:

i. Individuals being Deinstitutionalized from nursing facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities.

ii. Individuals being discharged from a hospital who, without Waiver Services, would be discharged to an Institution at a greater cost to Medicaid.

iii. Individuals, currently receiving long-term home health benefits, whose services could be delivered at a lower cost through a Waiver Benefit.

iv. Members with high Long-Term Services and Supports Level of Care Eligibility Determination Screen scores who are at imminent risk of Institutional placement.

d. Individuals denied program enrollment shall be informed of their appeal rights in accordance with Section 8.057.

8.7100.J Termination

1. The Department shall discontinue a Member's enrollment in an HCBS waiver when one of the following occurs:

a. The Member no longer meets the HCBS Waiver Benefit criteria,

b. The Member dies,

c. The Member enrolls in another HCBS waiver program or is admitted for a long-term stay beyond one month in an Institution, or

i. The Member does not receive an HCBS waiver service during a full one-month period, or

ii. The Member voluntarily withdraws from the HCBS waiver program.

8.7101 HCBS Waiver Program-Specific Member Eligibility

8.7101.A Children's HCBS Waiver (CHCBS)

1. Target Group Criteria:

2. To be eligible for the HCBS-CHCBS waiver, a child shall meet the following Target Group Criteria:

a. Is under 18 years of age.

b. Lives at home with Parent(s) or Guardian.

c. Meets Hospital Level of Care the state additionally limits the waiver to the subcategory of acute Hospital Level of Care or Nursing Facility Level of Care the State additionally limits the waiver to the subcategory of skilled nursing facilities Level of Care.

d. Meets federal SSI disability definition.

e. The child's Parent(s) or Guardian chooses to receive services in the home or community instead of an Institution.

f. The child is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs due to parental income and/or resources.

3. Medicaid Eligibility Groups Served in the Waiver

a. CHCBS Waiver Services are available to eligible individuals who meet the criteria set forth at 42 C.F.R. § 435.217 (2024). 42 C.F.R. § 435.217 (2024) is hereby incorporated by reference. This incorporation by reference excludes later amends to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-403(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E. 17th Ave., Denver, CO 80203. Certified copies are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at www.federalregister.gov.

4. Other

a. To be eligible for the CHCBS waiver, the income and resources of the child shall not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance.

b. Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list maintained by the Utilization Review Contractor (URC).

c. A child on the waiting list shall be prioritized for enrollment in the waiver if they meet any of the following criteria:

d. Have been in a hospital for one month or longer and require Waiver Services in order to be discharged from the hospital.

e. Are on the waiting list for an organ transplant.

f. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

g. Have received a terminally ill prognosis from their physician.

8.7101.B Children's Extensive Support Waiver (HCBS-CES)

1. Target Group Criteria

2. To be eligible for the HCBS-CES waiver, an individual shall meet the Target Group Criteria as follows:

a. Is unmarried and under 18 years of age.

b. Has a Developmental Disability (which includes a Developmental Delay if under five years of age) and requires long term services and supports to remain in the Family home.

c. Meets Intermediate Care Facilities for Individuals with Intellectual Disabilities Level of Care as determined by the Level of Care Screen.

d. Resides in an eligible HCBS-CES waiver setting, defined as:

i. Residing with biological or adoptive Parent(s), or Legal Guardian, or

ii. Residing in an out-of-home placement and can return home with the provision of HCBS-CES Waiver Services with the following requirements:

1) The Case Manager shall work with the residential caregiver to develop a transition plan that includes timelines and identified services or supports requested during the time the Member is not residing in the Family home. The Case Manager shall submit the transition plan to the Department for approval prior to the start of services.

iii. Meets the definition of disability set forth at 42 U.S.C. § 423(d).

iv. Meets the HCBS-CES waiver Member eligibility criteria:

1) The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection, or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be

considered beyond what is typically age appropriate and due to one or more of the following conditions:

a) A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life-threatening condition or situation,

b) A significant pattern of serious aggressive behavior toward self, others, or property, or

c) Constant vocalizations such as screaming, crying, laughing, or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of 15 minutes each waking hour.

2) For purposes of this subsection 6, Significant Pattern is defined as a behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six (6) months.

3) To remain eligible for Waiver Services, the annual Reassessment must demonstrate that in the absence of the existing interventions or preventions provided as Waiver Services, the intensity and frequency of the behavior or medical condition would return to a level that would meet the criteria listed above.

3. Medicaid Eligibility Groups Served in the Waiver

a. HCBS-CES Waiver Services are available to eligible Individuals in the following State Plan eligibility groups:

i. SSI recipients

ii. Optional state plan recipients

4. Other

a. Individuals who are determined eligible for HCBS-CES Waiver Benefits who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a waiting list maintained by the Department.

8.7101.C Children's Habilitation Residential Program Waiver (HCBS-CHRP)

1. Target Group Criteria

2. To be eligible for the HCBS-CHRP waiver, an individual shall meet the Target Group Criteria as follows:

    a. Is under 21 years of age.

    b. Has Extraordinary Needs that put the individual at risk or in need of out-of-home placement as identified in one of the two following manners:

        i. Meets Intermediate Care Facilities for Individuals with Intellectual Disabilities Level of Care as determined by the Level of Care Screen, and

            1) has been determined to have a Developmental Disability as determined pursuant to Section 8.607or if under five years of age, a Developmental Delay, or

        ii. Has a Serious Emotional Disturbance (SED) as defined in Section 8.7100.A as documented in a format prescribed by the Department, and the individual under 21 years old either

            1) meets Nursing Facility Level of Care as determined by the Level of Care Screen or,

            2) as documented in a format prescribed by the Department, the individual experienced inpatient psychiatric care, was at risk of inpatient psychiatric care, or was determined to require inpatient psychiatric care.

3. Medicaid Eligibility Groups Served in the Waiver

4. HCBS-CHRP Waiver Services are available to eligible Members in the following State Plan eligibility groups:

    a. Children for whom foster care maintenance payments are being made by the County Departments of Human/Social Services and who otherwise meet eligibility criteria.

    b. Individuals who meet the criteria set forth at 42 CFR §435.217.

5. Other

    a. An Assessment of the level of support needed shall be completed upon determination of eligibility and shall determine the level of reimbursement for Habilitation and per diem Respite services.

    b. Individuals determined eligible for benefits under the HCBS-CHRP waiver, who cannot be served within the capacity limits of the federally approved

waiver, shall be eligible for placement on a waiting list maintained by the Department.

8.7101.D Children with Complex Health Needs Waiver (HCBS-CwCHN)

1. Target Group Criteria:

2. To be eligible for the HCBS-CwCHN waiver, an individual shall meet the Target Group Criteria as follows:

   a. Is under 19 years of age,

   b. Meets a Level of Care, as determined by the state prescribed Level of Care Assessment instrument defined in 8.401.16, furnished in one of the following:

      i. Nursing Facility

      Ii. Hospital

         1. To meet Hospital Level of Care for CwCHN, a member must either:

            a. Have a diagnosis of a Life-Limiting Illness (i.e. a life-limiting medical condition or set of life-limiting medical conditions) as certified by a licensed medical professional and documented as prescribed by the Department upon enrollment.

      Or:

            b. One of the following conditions applies to the participant, documented as prescribed by the Department upon initial enrollment:

               i. Technologically dependent for life or health-sustaining functions, OR

               ii. Complex medication regimen or medical interventions to maintain or improve health status, OR

               iii. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health, or development at risk.

3. Medicaid Eligibility Groups Served in the Waiver:

4. HCBS-CwCHN Waiver Services are available to eligible individuals in the following State Plan eligibility groups:

    a. Meets federal SSI disability definition and/or is an SSI recipient

    b. Optional State Plan recipients

5. Waiting List

    a. Individuals who are determined eligible for benefits under the HCBS-CwCHN Waiver , and who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a waiting list maintained by the Department.

    b. A child on the waiting list shall be prioritized for enrollment in the waiver if they meet any of the following criteria:

        i. Have been in a hospital for one month or longer and require Waiver Services in order to be discharged from the hospital.

        ii. Are on the waiting list for an organ transplant.

        iii. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

        iv. Have received a terminally ill prognosis from their physician.

6. Other

    a. To be eligible for the CwCHN waiver, the income and resources of the child shall not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance.

8.7101.E Persons with Brain Injury Waiver (HCBS-BI)

1. Target Group Criteria

2. To be eligible for the HCBS-BI waiver, an individual shall meet the Target Group Criteria as follows:

    a. Is determined to have a Brain Injury that occurred prior to the individual's 65th birthday.

        i. Brain Injury is defined as an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and/or behavioral difficulties of a non-progressive nature and is limited to the to the broad diagnoses found within the most current version of the ICD.

b. Is 16 years of age or older.

c. Meets Nursing Facility Level of Care;

d. Meets Hospital Level of Care and as evidenced by:

i. The individual shall have been:

1) Referred to the Case Management Agency while receiving inpatient care in an acute care or rehabilitation hospital for the treatment of the individual's Brain Injury; or

2) A comprehensive functional Assessment using the Long-term Services and Supports Level of Care Screen results in at least the minimum scores required by Section 8.7202.E, demonstrating a functional need for nursing facility Level of Care.

ii. The individual shall require goal-oriented therapy with medical management by a physician.

iii. The individual shall not be therapeutically managed in a community-based setting without significant supervision and structure, specialized therapy, and support services.

3. Medicaid Eligibility Groups Served in the Waiver

4. HCBS-BI Waiver Services are available to eligible Members in the following State Plan eligibility groups:

a. SSI recipients

b. Optional state plan recipients

c. Working individuals with disabilities who buy into Medicaid (BBA Working Disabled Group as described in 42 U.S.C §1902 1396a(a)(10)(A)(ii)(XIII))

d. Working individuals with disabilities who buy into Medicaid TWWIIA Basic Coverage Group as provided in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV of the Act)

5. Other

a. Persons determined eligible for HCBS-BI services that cannot be served within the capacity limits of the HCBS-BI waiver shall be eligible for placement on a waiting list maintained by the Department.

8.7101.F Community Mental Health Supports Waiver (HCBS-CMHS)

1. Target Group Criteria

2. To be eligible for the HCBS-CMHS waiver, an individual shall meet the Target Group Criteria as follows:

    a. Is experiencing a severe and persistent mental health need that requires assistance with one or more ADLs. For purposes of this subsection, a person experiencing a severe and persistent mental health need is defined as one who:

        i. Is 18 years of age or older with a severe and persistent mental health need,

        ii. Currently has or at any time during the one-year period prior to Assessment had a diagnosed mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM -5):

            1) Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and

            2) Has resulted in functional impairment which substantially interferes with or limits one or more major life activities, and

        iii. A severe and persistent mental health need does not include:

            1) Intellectual or developmental disorders; or

            2) Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.

    b. Meets Nursing Facility Level of Care.

    c. A length of stay shall be assigned by the Utilization Review Contractor (URC) for approved admissions, according to guidelines at Section 8.402.30.

3. Medicaid Eligibility Groups Served in the Waiver

4. HCBS-CMHS Waiver Services are available to eligible Members in the following State Plan eligibility groups:

    a. SSI recipients

    b. Optional state plan recipients

c. Working individuals with disabilities who buy into Medicaid BBA Working Disabled Group as described in described in 42 U.S.C § 1396a(a)(10)(A)(ii)(XIII)

d. Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1396a(a)(10)(A)(ii)(XV) of the Act

8.7101.G Elderly, Blind, And Disabled Waiver (HCBS-EBD)

1. Target Group Criteria

2. To be eligible for the HCBS-EBD waiver, an individual shall meet the Target Group Criteria as follows:

   a. Is determined by the Case Management Agency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult.

   b. Meets the minimum and/or if applicable maximum age for individuals served in each subgroup

   c. Aged: Be 65 years of age or older

      i. Physically Disabled or Blind: Be 18-64 years of age (Those participants who are physically disabled who reach the age of 65 shall automatically get classified as Aged with no break in services), and/or

      ii. HIV/AIDS: Be 18 years of age or older.

   d. Meets Nursing Facility Level of Care.

3. Medicaid Eligibility Groups Served in the Waiver

4. HCBS-EBD Waiver Services are available to eligible Members in the following State Plan eligibility groups:

   a. SSI recipients

   b. Optional state plan recipients

   c. Working individuals with disabilities who buy into Medicaid (BBA Working Disabled Group as described in §1396a (a)(10)(A)(ii)(XIII))

   d. Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1396a (a)(10)(A)(ii)(XV) of the Act

5. Other

a. HCBS-EBD Members that enter a nursing facility or hospital may not receive HCBS-EBD Waiver Services while residing in the nursing facility or hospital unless prior authorization has been received from the Department.

i. HCBS-EBD Members admitted to a nursing facility or hospital for one calendar month or longer shall be discontinued from the HCBS-EBD program.

ii. HCBS-EBD Members entering a nursing facility for Respite Care as an HCBS-EBD service shall not be discontinued from the HCBS-EBD program.

b. Individuals determined eligible for HCBS-EBD services that cannot be served within the capacity limits of the HCBS-EBD waiver shall be eligible for placement on a waiting list.

8.7101.H Complementary and Integrative Health Waiver (HCBS-CIH)

1. Target Group Criteria

2. To be eligible for the HCBS-CIH waiver, an individual shall meet the Target Group Criteria as follows:

a. Is 18 years of age or older.

b. Has a qualifying condition of a spinal cord injury (traumatic or nontraumatic), multiple sclerosis, a Brain Injury, spina bifida, muscular dystrophy, or cerebral palsy with the Inability for Independent Ambulation directly resulting from one of these conditions as defined by broad diagnoses related to each condition within the most current version of the ICD at the time of Assessment.

c. Be unable to ambulate independently as a result of the qualifying condition as identified by the Case Manager through the Level of Care Screen process. A person is considered unable to ambulate independently if:

i. The individual does not walk, and requires use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own; or

ii. The individual does walk, but requires the use of a walker or cane in all settings, whether they can use the walker or cane safely, on their own; or

iii. The individual does walk but requires “touch” or “stand-by” assistance to ambulate safely in all settings.

d. Meets Hospital Level of Care or Nursing Facility Level of Care.

3. Medicaid Eligibility Groups Served in the Waiver

a. HCBS-CIH Waiver Services are available to eligible individuals in the following State Plan eligibility groups:

i. SSI recipients

ii. Optional state plan recipients

iii. Working individuals with disabilities who buy into Medicaid (BBA Working Disabled Group as described in 42 U.S.C § 1396a(a)(10)(A)(ii)(XIII)).

iv. Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1396a(a)(10)(A)(ii)(XV) of the Act

4. Other

a. Persons determined eligible for HCBS-CIH services that cannot be served within the capacity limits of the HCBS-CIH waiver shall be eligible for placement on a waiting list.

8.7101.I Supported Living Services Waiver (HCBS-SLS)

1. Target Group Criteria

2. To be eligible for the HCBS-SLS waiver, an individual shall meet the Target Group Criteria as follows:

a. Has an intellectual or Developmental Disability

b. Is 18 years of age or older.

c. Meets the Intermediate Care Facilities for Individuals with Intellectual Disabilities Level of Care.

d. Does not require 24-hour supervision on a continuous basis which is reimbursed as an HCBS-SLS service.

e. Resides in an eligible HCBS-SLS setting. An SLS setting is the individual's residence, which is defined as the following:

i. A living arrangement, which the individual owns, rents, or leases in their own name,

ii. The home where the individual lives with the Member's Family or legal Guardian, or

iii. A living arrangement of no more than three persons receiving HCBS Waiver Services residing in one household, unless they are all Members of the same family.

3. Medicaid Eligibility Groups Served in the Waiver

4. HCBS-SLS Waiver Services are available to eligible Members in the following State Plan eligibility groups:

a. SSI recipients

b. Optional state plan recipients

c. Working individuals with disabilities who buy into Medicaid (BBA Working Disabled Group as described in 42 U.S.C § 1396a(a)(10)(A)(ii)(XIII)).

d. Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1396a(a)(10)(A)(ii)(XV) of the Act

5. Other

a. Enrollment in the HCBS-SLS waiver may be limited when utilization of the HCBS-SLS waiver program is projected to exceed legislative pending authority.

b. When the HCBS-SLS waiver reaches capacity for enrollment, an individual determined eligible for a waiver shall be placed on a waiting list.

c. As openings become available in the HCBS-SLS waiver program in a designated service area, individuals shall be considered for services in order of placement on the local Case Management Agency's waiting list regarding an appropriate match to services and supports. Exceptions to this requirement shall be limited to situations in which:

i. An emergency greatly endangers the health, safety, and welfare of the individual or others and the emergency cannot be resolved in another way. For the purposes of this subsection, emergencies are defined as follows:

1) Homelessness: the individual does not have a place to live or is in imminent danger of losing their place of abode.

2) Abusive or Neglectful Situation: the individual is experiencing ongoing physical, sexual, or emotional abuse or neglect in

their present living situation and their health, safety or well-being are in serious jeopardy.

3) Danger to Others: the individual's behavior or psychiatric is such that others in the home are at risk of being hurt by them. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

4) Danger to Self: an individual's medical, psychiatric, or behavioral challenges are such that they are seriously injuring/harming themselves or are in imminent danger of doing so.

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

e. If an eligible individual is placed on a waiting list for SLS Waiver Services, a written notice, including information regarding the Member appeals process, shall be sent to the individual and/or his/her legal Guardian in accordance with the provisions of Section 8.057, et seq.

8.7101.J Developmental Disabilities Waiver (HCBS-DD)

1. Target Group Criteria

2. To be eligible for the HCBS-DD waiver, an individual shall meet the Target Group Criteria as follows:

   a. Has an intellectual or Developmental Disability.

   b. Requires access to 24-hour services and supports to meet daily living needs that allow them to live safely and participate in the community.

   c. Is 18 years of age or older.

   d. Meets Intermediate Care Facilities for Individuals with Intellectual Disabilities Level of Care.

3. The State may limit the number of Members enrolled in the HCBS-DD waiver at any point in time during a waiver year. When the HCBS-DD waiver reaches capacity for enrollment, an individual determined eligible for the waiver shall be eligible for placement on a waiting list.

   a. The state reserves capacity for the following purposes:

i. Emergency in which positions are reserved for individuals whose names are on the waiting list, who are experiencing a Crisis, and require immediate assistance to ensure their health and safety,

ii. 18-21 Transition in which positions made available for children who are adopted through the Colorado Child Welfare system, reach an age at which they are no longer eligible for foster care, the HCBS-Children's Extensive Supports waiver, or the HCBS-Children's Habilitation Residential Program waiver in order to continue access to services that will allow them to continue living safely in the community without interruption, and

iii. Deinstitutionalization for Nursing Facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and State Mental Health Institutes in which positions are made available for individuals who have requested to transition from one of these settings to a community setting, and

iv. Waitlists. As vacancies occur in waiver enrollments, the state shall enroll the next individual on the waiting list based on the statewide order of the selection date.

4. Medicaid Eligibility Groups Served in the Waiver

5. HCBS-DD Waiver Services are available to eligible Members in the following State Plan eligibility groups:

   a. SSI recipients

   b. Optional state plan recipients

   c. Working individuals with disabilities who buy into Medicaid (BBA Working Disabled Group as Medicaid as described in 42 U.S.C § 1396a(a)(10)(A)(ii)(XIII))

   d. Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as described in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV) of the Act

6. Other

   a. The Member shall maintain eligibility by meeting the General Eligibility and waiver program-specific requirements set forth herein and maintaining residence in a GRSS or IRSS setting.

   b. Enrollment in the HCBS-DD waiver may be limited when utilization of the HCBS-DD waiver program is projected to exceed legislative pending authority.

c. When the HCBS-DD waiver reaches capacity for enrollment, an individual determined eligible for a waiver shall be placed on a waiting list.

d. As openings become available in the HCBS-DD waiver program, individuals shall be considered for services in order of placement on the statewide waiting list. Exceptions to this requirement shall be limited to situations in which:

i. An emergency greatly endangers the health, safety, and welfare of the individual or others and the emergency cannot be resolved in another way. For the purposes of this subsection, emergencies are defined as follows:

1) Homelessness: the individual does not have a place to live or is in imminent danger of losing their place of abode.

2) Abusive or Neglectful Situation: the individual is experiencing ongoing physical, sexual, or emotional abuse or neglect in their present living situation and their health, safety or well-being are in serious jeopardy.

3) Danger to Others: the individual's behavior or psychiatric is such that others in the home are at risk of being hurt by them. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

4) Danger to Self: an individual's medical, psychiatric, or behavioral challenges are such that they are seriously injuring/harming themselves or are in imminent danger of doing so.

5) 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.

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

f. If an eligible individual is placed on a waiting list for DD Waiver Services, a written notice, including information regarding the Member appeals process, shall be sent to the individual and/or his/her legal Guardian in accordance with the provisions of Section 8.057, et seq.

8.7200 Case Management Agency Requirements

8.7200.A Colorado Case Management System

1. The Colorado Case Management System consists of Case Management agencies representing defined service areas throughout the state, for the purpose of providing assistance to persons in need of long-term services & support, including but not limited to Home and Community-Based Services.

8.7200.B Definitions

1. Assessment means a comprehensive evaluation with the individual seeking services and appropriate supports (such as Family Members, advocates, friends and/or caregivers), chosen by the individual, conducted by the Case Manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources.

2. Case Management Agency is defined in Section 8.7100.A.8

3. Case Management Agency Defined Service Area means one or more counties that have been designated as a geographic region in which one Agency serves as the Case Management Agency for persons in need of Home and Community-Based Waiver Services or Long Term Services and Supports.

4. Case Management Activities 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.

    a. Case Management Activities means all activities performed by a Case Management Agency reimbursed through contracts and Targeted Case Management.

        i. Administrative Case Management includes activities that are reimbursed through contracts with the Department of Health Care Policy and Financing.

        ii. Targeted Case Management refers to coordination and planning services provided with, or on behalf of, an individual Member.

Targeted Case Management is a state plan benefit and is reimbursed through direct billing, not contract payments.

5. Case Manager means an employee of a Case Management Agency, as defined at Section 8.7100.A.8, who performs the required Case Management Activities.

6. Colorado General Assembly means the legislature of the State of Colorado, comprising both the state senate and the state house of representatives.

7. Community Centered Board (CCB) means a private for-profit or not-for-profit organization that is an administrator of locally generated funding pursuant to § 25.5-10-206(6), C.R.S. and acts as a resource for persons with an Intellectual and Developmental Disability or a child with a Developmental Delay.

8. Complaint means any statement received by an individual or Member as it relates to unsatisfactory services provided through the Case Management Agency to include, but not limited to: general business functions, administration, State General Fund program functions, and Case Management functions. Complaints regarding activities outside the scope of work for the Case Management Agency are excluded from this definition.

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

10. Conflict-Free Case Management Waiver means the Case Management Agency may provide direct services to Members for whom it provides Case Management services.

11. Corrective Action Plan means a written plan by the Case Management Agency, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

12. Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a Member; including events that 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.

13. Defined Service Area means the geographical area the Department determines shall be served by a Case Management Agency.

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

15. Home and Community-Based Services (HCBS) Waivers is as defined in Waiver Eligibility Requirements Section 8.7100 et seq.

16. In-Reach Counseling is a service designed to engage and provide institutionalized population Members with information regarding housing, transition, and other community-based services available to support them living in the community; and to answer any questions that may arise either in a group setting or individually

17. Intellectual and Developmental Disability has the same meaning set forth in Section 25.5-6-403 (3.3)(a), C.R.S and Section 8.7100.A.40.

18. Information Management System (IMS) means an automated data management system approved by the Department to enter Case Management information for each individual seeking or receiving long-term services as well as to compile and generate standardized or custom summary reports.

19. Intake, Screening and Referral means the initial contact with individuals by the Case Management Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for Long-Term Services and Supports; an individual's need for Referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive Functional Needs Assessment of the individual seeking services.

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

21. Long Term Services and Supports Level of Care Eligibility Determination Screen (Level of Care Screen) means a comprehensive evaluation with the individual seeking services and appropriate support persons (such as Family Members, friends, and or caregivers) to determine an Applicant or Member’s eligibility for Long-Term Services and Supports based on their need for institutional Level of Care as determined using the Department’s prescribed Assessment instrument as outlined in Section 8.7202.E.

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

    a. Children’s Home and Community-Based Services (HCBS-CHCBS)

b. Developmental Disabilities (HCBS-DD)

c. Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD)

d. Home and Community-Based Services Complementary and Integrative Health (HCBS-CIH)

e. Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI)

f. Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS)

g. Home and Community-Based Services for Children with Life Limiting Illness (HCBS-CLLI), and

h. Home and Community-Based Services Supported Living Services (HCBS-SLS)

i. Children's Extensive Support Waiver (HCBS-CES)

j. Children's Habilitative Residential Program (HCBS-CHRP)

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

24. Member Identified Team means the people, agencies or representatives a Member selects to participate to support in their long-term care programs, processes and procedures including but not limited to their service planning or other waiver program processes and procedures. Members may choose specific people or agencies and may select which portions of their program they want the team to be involved with. Members may revoke or change this team at any time. "Member Identified Team" applies to all waivers and replaces Interdisciplinary Team in former rules applicable to people with Intellectual and Developmental Disabilities.

25. Pre-Admission Screening and Resident Review (PASRR) is as defined in Section 8.401.18.

26. Person-Centered Case Management means Case Management services that offer people dignity, compassion and respect while facilitating Assessments and planning that support people to recognize and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

27. Person-Centered Support Planning means the process of working with the Member and people chosen by the individual to identify goals, needed services,

individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' Assessment and knowledge of the individual and of community resources. Support Planning informs the individual seeking or receiving services of his or her rights and responsibilities.

28. Post Reintegration Survey is a series of questions found in the Department's prescribed system that Case Managers ask Members at their next contact or within ninety (90) days of transitioning back into the community, to gain the Member's perspective on the transition process. It is the final step in the Rapid Reintegration process.

29. Rapid Referral is the Person-Centered process that occurs when an Individual, who is seeking admission to a nursing facility, is interested in, or does not oppose living in the community, and is experiencing unstable housing and/or requiring additional supported services, is then assigned to a Transition Coordination Agency for transition coordination.

30. Rapid Reintegration is the Person-Centered process that occurs when an Individual who is seeking admission to a nursing facility, is interested in, or does not oppose, living in the Community, and has stable housing receives services as described in the Rapid Reintegration Plan.

31. Rapid Reintegration Barrier Questions is a series of questions in the Department's prescribed system that Case Managers complete during the Rapid Reintegration initiation process. These questions will identify and document barriers that may affect the member's transition back to the community. Based on responses the Case Manager will either complete a Rapid Referral or a Rapid Reintegration Plan.

32. Rapid Reintegration Plan is a written Person-Centered plan developed for the purpose of rapidly transitioning a Member from a nursing facility into the community.

33. Reassessment means a periodic reevaluation with the Member, their chosen supports, and Case Manager, to re-determine the individual's level of functioning, service needs, available resources and potential funding resources.

34. State General Fund (SGF) Programs means programs funded solely through the Colorado State General Fund. Those include but are not limited to: State Supported Living Services (State-SLS) at Section 8.7202.V.4, Specialized Nursing Care Services,and Family Support Services Program (FSSP) at Section 8.7561.

35. Target Group Criteria means the factors that define a specific population to be served through an HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic conditions, age, or diagnosis, and May include other criteria such as demonstrating an exceptional need.

36. 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 coordination services for those transitioning from facility-based care to community-based care pursuant to a Provider Participation Agreement with the state department.

37. Transition Escalation is an increase in the severity or seriousness of an issue, typically tied to whether the applicant or Member's case is, or has been, impacted by the actions taken or not taken by the member's transition team.

38. Waiver Benefit means covered benefits offered in addition to or as an alternative to state plan benefits as authorized by 42 U.S.C. § 1396n(c) and include the Waiver Benefits described in Section 8.7101 for the following programs: Children's Home and Community-Based Services Waiver (CHCBS); Children's Extensive Support Waiver (HCBS-CES); Children's Habilitation Residential Program Waiver (HCBS-CHRP); Children With Life Limiting Illness Waiver (HCBS-CLLI); Persons With Brain Injury Waiver (HCBS-BI);Community Mental Health Supports Waiver (HCBS-CMHS); Elderly, Blind and Disabled Waiver (HCBS-EBD); Complementary and Integrative Health Waiver (HCBS-CIH; Supported Living Services Waiver (HCBS -SLS);and Developmental Disabilities Waiver (HCBS-DD).

8.7200.C Legal Basis

1. Pursuant to Section 25.5-6-1701, C.R.S., the State Department is authorized to provide for a statewide Case Management system.

8.7200.D Case Management Agency Defined Service Areas

1. Case Management Agency Defined Service Areas shall meet the following requirements:

2. Counties composing a multi-county service area shall be contiguous.

3. A single county may be designated as a Defined Service Area provided the county serves a monthly average of 400 or more individuals for receiving Long-Term Services and Supports.

4. Multi-county service areas shall also be required to serve a minimum number of individuals Members of 400.

5. Case Management services shall be provided to Members by the Case Management Agency awarded the contract for the Member's county of residence.

6. Each Case Management Agency shall have an exceptions process and policy for serving Members outside of their Defined Service Area and for Members to request to be served by an Agency outside their service area. Each Case

Management Agency shall submit the exceptions process and policy to the Department for approval by a method determined by the Department and shall review the process and policy with the Community Advisory Committee and Governing Body at least once per contract period.

7. When a Member in a Case Management Agency's defined serve area requests to transfer to a Case Management Agency outside the Member's Defined Service Area, the Case Management Agencies shall coordinate the transfer in accordance with transfer rules 8.7202.M. Case Management Agencies shall provide a report on their process and the number of Members served outside their Defined Service Area upon Department request.

8.7200.E Case Management Agency Selection and Contracting

1. Case Management Agency Competitive Procurement Process

2. The Department shall select Case Management Agencies in accordance to applicable requirements of Title 24, Articles 101-112, C.R.S., and 1 CCR 101-9.

3. Case Management Agency Contract

    a. Case Management Agency shall be bound to all requirements identified in the contract between the Agency and the Department including but not limited to quality assurance standards and compliance with the Department's rules and federal regulation applicable for Case Management Agencies and for all Long-Term Services and Supports programs.

8.7201 Case Management Agency Overall Requirements

8.7201.A Administration of a Case Management Agency

1. The Case Management Agency shall be required in their mission statement, by-laws, articles of incorporation, and contracts, to comply with all regulations which govern the Case Management Agency, and to comply with the following standards:

    a. The Case Management Agency shall serve individuals in need of Long-Term Services and Supports as defined in Section 8.7100.A.48

    b. The Case Management Agency shall have the capacity to accept funding from multiple sources;

c. The Case Management Agency may subcontract with individuals, for-profit entities and not-for-profit entities to provide Case Management Agency Targeted Case Management and administrative Case Management Activities up to the limitations established in the Case Management Agency contract. Subcontractors must abide by the terms of the Case Management Agency contract with the Department and are obligated to follow all applicable federal and state statutes and regulations. The Case Management Agency is responsible for subcontractor performance.

d. The Case Management Agency may receive funds from public or private foundations and corporations; and

e. The Case Management Agency shall be required to publicly disclose all sources and amounts of revenue as described in Section 25.5-6-1708 CRS.

2. The Case Management Agency shall fulfill all functions of a Case Management Agency and Case Manager as described in these rules.

3. The Case Management Agency shall:

a. Not provide guardianship services for any individual applying for Long-Term Services and Supports or Member enrolled in a Long-Term Services and Supports program.

b. 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 individual, Member and/or persons inquiring upon their behalf.

c. Be separate from the delivery of direct services and supports paid for by any payer for the same individual they provide Case Management, unless otherwise approved by the Department through a Conflict Free Case Management Waiver and except pursuant to Section 8.7202.W when the Case Management Agency is acting as the Organized Health Care Delivery System, or approved by the Department through a Conflict Free Case Management Waiver and in accordance with Section 25.5-6-1703(6) C.R.S.

d. Establish and maintain working relationships through Memorandum of Understanding processes and procedures with community-based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the individuals' and Members' needs including but not limited to local Regional Accountable Entities, Behavioral Health Administration, Aging and Disability Resource Centers, counties, schools, and Medical Assistance sites as necessary for individual and Member support.

e. Maintain a website that at a minimum contains contact information for the Case Management Agency, the ability for electronic communication, hours of operation, available resources, program options, services provided, and the transparency documentation required in Section 25.5-6-1708 C.R.S.

f. Provide Case Management services without Discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression or disability.

4. The Department may grant a Case Management Agency a Conflict Free Case Management waiver (CFCMW) to provide direct services and Case Management in the event that no other willing and qualified providers are available for the capacity of Member services necessary.

a. Applications for this waiver shall be received and evaluated in the manner in which has been communicated by the Department.

b. The Department may grant a Case Management Agency a Conflict-Free Case Management Waiver (formerly known as a rural exception) to provide specific direct services within their Defined Service Area to ensure access to these services in rural and frontier areas across Colorado.

c. The Case Management Agency shall:

i. Submit a formal application (found on the Department website) for a Conflict-Free Case Management Waiver.

ii. The Department shall provide formal notification to the Case Management Agency within 10 business days of the receipt of the application. The Department shall notify Applicants of their approval or denial within 90 days of receipt of the application.

iii. If the Applicant submits a response to the Case Management Agency Request for Proposal (RFP), the Department shall notify the Agency of approval or denial prior to the delivery of intent to award letters to RFP Respondents or within 90 day of receipt of the application whichever occurs first.

iv. If the Conflict-Free Case Management Waiver application is denied, the Department will coordinate with the Case Management Agency for a transition period, if necessary.

v. If a Case Management Agency requires a waiver between Case Management Agency contract cycles, the Case Management Agency must submit the application for the Conflict Free Case Management Waiver and maintain the documentation for the next RFP submission.

1) If the Conflict-Free Case Management Waiver application is approved, the Department will coordinate with the Case Management Agency for next steps in implementation and execution, if necessary.

2) If the Conflict-Free Case Management Waiver application is denied, the Department will coordinate with the Case Management Agency for a transition period within their contract period, if necessary.

vi. A Case Management Agency that is granted a Conflict-Free Case Management Waiver shall provide an annual report to the Department subject to Department approval that includes but will not be limited to:

1) a summary of individuals participating in direct services and Case Management;

2) how the Case Management Agency has ensured informed consent and/or choice, if other providers exist in the Defined Service Area; and

3) how the Case Management Agency continues to support the recruitment of willing and qualified providers in their Defined Service Area.

4) how the direct service provider functions and Case Management Agency functions are administratively separated (including staff) with safeguards in place to ensure a distinction between direct services and Case Management exists as a protection against conflict of interest.

vii. If a new service provider(s) becomes available in the area, the Case Management Agency may continue to provide direct services until the Department has determined that the alternate provider(s) is capable of meeting all needs in that service area.

viii. If other service providers are available in the area, the Case Manager must document the offering of choice of provider and/or that no provider had capacity to serve new Members in the Information Management System.

ix. To ensure conflict of interest is being mitigated by the Case Management Agency, the Department will conduct annual quality reviews that will include but not be limited to, reviews of documentation of Members' choice of provider and informed consent for services.

8.7201.B Case Management Agency Governing Body

1. Each Case Management Agency shall assemble a governing body or board of directors that complies with requirements in Section 25.5-6-1708 C.R.S.

    a. The Case Management Agency shall maintain all meeting agendas, minutes, and documents that are required to be posted on the Case Management Agency's website for at least three months after posting.

    b. The Case Management Agency shall maintain all contracts, financial statements, and 990s that are required to be posted on the Case Management Agency's website on its website for at least three calendar years after posting.

    c. The Case Management Agency shall not screen or divert any email that is sent to a member of the board of directors or governing body of a Case Management Agency. The Case Management Agency shall ensure that all emails addressed to a member of the board of directors or governing body are delivered to that member.

        i. In the event a member of the board of directors or governing body is unable to access a computer or needs assistance with email, the Case Management Agency shall provide appropriate assistance, including providing emails in alternative formats upon request or mailing correspondence through the U.S. postal service.

    d. The Department shall maintain a website form for community members to make anonymous Complaints regarding the Case Management Agency compliance with the transparency requirements in C.R.S. 25.5-6-1708. The Case Management Agency and its governing body shall comply with the Department's direction for responding to all Complaints.

2. The Case Management Agency governing body function shall include but not be limited to:

    a. Financial oversight and solvency

    b. Ensuring accountability and the provision of high quality Case Management

    c. Ensuring a working Community Advisory Committee convenes at least quarterly

    d. Resolving disputes between individuals, Members and Case Management Agency that are elevated to the governing body and

    e. Developing and presenting the Long-Range Plan annually to the Department

f. Ensuring adherence to all state and federal regulations and contractual obligations and requirements.

8.7201.C Community Advisory Committee

1. The Case Management Agency shall establish and maintain a community advisory committee for the purpose of providing public input for Case Management Agency operations.

2. The Community Advisory Committee Responsibilities shall include:

   a. Monthly review of Case Management Agency Complaint log

   b. Receiving Complaints from the community regarding the Case Management Agency via open forum at their meetings

   c. Supporting Case Management Agency in resolving Complaints with Members, including Referral to the Department's escalation process

   d. Making recommendations to the Case Management Agency about policies and procedures, and

   e. Providing public input and guidance to the Case Management Agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall Case Management Agency operations, service quality, individual Member satisfaction, resolution of Complaints at the local level and other related professional problems or issues.

3. Community Advisory Committee Membership

   a. The Case Management Agency shall demonstrate efforts to recruit and support members of the Community Advisory Committee who represent the characteristics of the community as it relates to diversity of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, abilities, and disabilities, and socio-economic status.

   b. The membership of the Community Advisory Committee shall include regional representation from, but not be limited to, at least one of each of the following:

      i. The Defined Service Area's county commissioners, area agencies on aging, medical professionals, physical and/or intellectual disability professionals, ombudsmen, human service agencies, county government officials, mental/behavioral health professionals, and

ii. Regional representation from one or more Long-Term Services and Supports Members or Family Members of individuals receiving Long-Term Services and Supports including Members with I/DD and/or Members with disabilities.

1) Members shall be given priority of selection over Family Members.

iii. The Case Management Agency shall make every effort to recruit and maintain a majority of members or people with lived experience on the Community Advisory Committee over professionals as outlined in 8.7201.C.3.b.i-ii. If the Case Management Agency is unable to maintain this majority, the Case Management Agency shall submit the attempts at recruitment with their annual report to the Department.

c. The Community Advisory Committee shall have a membership count and quorum based on the number of people served. The quorum must include a majority of Members or people with lived experience.

i. Case Management Agencies serving 400-2000 people will have a committee membership count of 5 minimum with a quorum of 3.

ii. Case Management Agencies serving 2001-7000 people will have a committee membership of 7 minimum with a quorum of 4.

iii. Case Management Agencies serving 7001 or more people will have a committee membership of 9 with a quorum of 5.

d. In the event a Community Advisory Committee is comprised of greater than the minimum number of committee members, the quorum shall be a simple majority.

i. If the quorum is not reached, the meeting may continue but the committee must abstain from final recommendation votes until the quorum is met.

4. The Community Advisory Committee shall function only as an advisory body providing recommendations to the Case Management Agency and Case Management Agency governing body and shall have no decision-making power.

5. The Case Management Agency shall train the Community Advisory Committee members in confidentiality, mandatory reporting and disability cultural competency.

6. The Community Advisory Committee shall maintain public notices in accordance with confidentiality requirements of the following: meetings,

meeting minutes, and documentation of actions taken in response to recommendations and Complaints. Public notices of meetings shall be made available online and by request for increased equitable access.

7. The Community Advisory Committee shall provide options for equitable access to meetings including live, online audiovisual access to meetings.

8. The Community Advisory Committee shall report to the Case Management Agency governing body quarterly on all Case Management complaints trends and documentation of actions taken in response to recommendations and complaints. These reports shall be made public.

9. The Community Advisory Committee shall provide reports to the Department and its committees upon request. These reports shall be made public.

10. The Community Advisory Committee may be combined in purpose or name with other Case Management Agency committees in the Case Management Agency Defined Service Area so long as it meets the above purpose, criteria and reporting requirements.

11. The Case Management Agency must provide an annual summary of the Community Advisory Committee's activities over the prior year in its Long Range Plan and presentation to the Department

8.7201.D Case Management Agency Complaint Process for Individuals and Members

1. Every Case Management Agency shall use the Department prescribed Case Management Agency Complaint log and have procedures setting forth a process for the timely resolution of Complaints received from a Member, Parent(s) of a minor, Guardian and/or other Legally Authorized Representative, as appropriate. The Case Management Agency shall not take any action that affects the future provision of appropriate services or supports based on the receipt of a Complaint from a Member or their Parent, Guardian or representative.

2. The procedure shall be provided, orally and in writing and in the communication method of the member's or guardian's choosing, to all Members, the Parents of a minor, Guardian and/or other Legally Authorized Representative, as appropriate, at the time of admission, at any time changes to the procedure occur and as part of the annual service planning process.

3. The Case Management Agency shall make all Complaint procedures available on their public facing website.

4. The Complaint procedure shall include, at a minimum, the following:

a. Contact information for a person within the Case Management Agency who will receive Complaints.

b. Identification of support person(s) who can assist the individual or Member in submitting a Complaint.

c. An opportunity to find a mutually acceptable solution. This could include the use of mediation if both parties voluntarily agree.

d. Timelines for resolving the Complaint.

e. Escalation of the Complaint to the Agency director or designee for consideration if the Complaint cannot be resolved at a lower level. This may include the Department escalation process, if necessary.

f. Assurances that no Member shall be coerced, intimidated, threatened, or retaliated against because the Member has exercised his or her right to file a Complaint or has participated in the Complaint process.

g. Review of redacted Complaint log and resolutions with the Community Advisory Committee.

5. The Department shall review the Complaint procedure and logs annually to ensure appropriate resolution of Complaints and provide feedback and follow up to Case Management Agency as necessary.

6. If an Agency goes without Complaints for more than two years, the Department shall require the Case Management Agency to complete a statistically valid customer satisfaction survey each year for each of the following two years.

7. The Department shall maintain a website form for community Members to make anonymous Complaints regarding the Case Management Agency.

8.7201.E Personnel System

1. The Case Management Agency shall have a system that complies with all rules, regulations, and Department communications for recruiting, retaining, hiring, evaluating, and terminating Case Management Agency employees including but not limited to

   a. Colorado Bureau of Investigations criminal history background check

   b. Colorado Adult Protective Services data system checks, and

   c. Verification of compliance with applicable state regulations.

2. Case Management Agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.

3. The Case Management Agency shall maintain a current job description for each employment position.

8.7201.F Staffing Patterns

1. Each Case Management Agency shall assure adequate staffing levels and infrastructure, including maintaining caseload sizes or ratios as set forth in contract, to effectively manage the Case Management Agencies' s caseload to ensure timely delivery of high-quality services. This includes at least one full-time Case Manager to provide Case Management functions and administrative support, and, as needed, additional Case Managers, case aids, supervisors, and other staff.

2. Within their staffing patterns, Case Management Agencies shall publicly post its policies and procedures and provide choice of Case Manager to Members served in their Defined Service Area and shall clearly communicate to each individual and Member the steps for requesting a new Case Manager.

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

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

4. Case Management Agencies shall ensure staff have access to statutes and regulations relevant to the provision of authorized services.

5. For each individual Members, Case Management Agencies shall assign one (1) primary Case Manager or point of contact who ensures Case Management services are provided on behalf of the Member or individual across all programs. Case Management Agencies must maintain a best practice standard in their policies and procedures for notification of a Member when a new Case Manager is assigned to a Member.

6. Case Management Agencies shall ensure persons who are employed by the Agency meet the requirements of these regulations.

7. Case Management Agencies shall verify and document that Case Managers who are employed meet minimum requirements and qualifications.

8. Case Management Agencies and their staff shall avoid situations that create the potential for a real or perceived conflict of interest. If a situation that may involve potential conflict of interest cannot be avoided, staff shall notify affected parties of possible the conflict of interest and policies and procedures in place to ensure protection of the Member or individual's rights.

8.7201.G Case Management Agency Communication and Documentation

1. The Case Management Agency shall:

    a. Comply with all reporting and billing policies and procedures established by the Department, document individual and Member records within the Department's prescribed systems and adhere to the system requirements provided by the Department for these systems.

    b. Have access to Member eligibility, Prior Authorization Request (PAR), and claims data reporting provided through a data query application, program eligibility determination, Financial Eligibility determination, Person-Centered Support Planning, service authorization, Critical Incident reporting and follow-up, monitoring of health and welfare, monitoring of services, information and Referral services provided by the Agency, Complaint trends and resolutions, resource development and fiscal accountability.

    c. Maintain individual and Member records within the Department's prescribed systems for the purposes of individual and Member information management.

    d. Maintain accurate and detailed documentation of all Case Management and State General Fund Program activities required by the Case Management Agency Contract and these rules.

    e. Maintain accurate and detailed supporting documentation in the Department's prescribed system within ten (10) business days of all activities as required through the Case Management Agency Contract and these rules to substantiate claims for reimbursement.

    f. Provide supporting documentation not already residing within the Department's prescribed systems to the Department upon request.

    g. Correct one hundred percent (100%) of data errors, discovered by the Department, and confirm the accuracy of the data it enters into the Department prescribed system within ten (10) Business Days of notification from the Department of an error.

    h. Provide information and reports as required by the Department including, but not limited to, data and records necessary for the Department to conduct operations.

2. The Case Management Agency shall have adequate phone and computer hardware and software for communication with Members, individuals, employees and stakeholders, compatible with the Information Management System with such capacity and capabilities as prescribed by the Department to manage the

administrative requirements necessary to fulfill the Case Management Agency responsibilities.

3. The Case Management Agency shall have adequate staff support to maintain a computerized information system in accordance with the Department's requirements.

8.7201.H Case Management Agency Individual and Member Recordkeeping

1. The Case Management Agency shall complete and maintain all required records in the Information Management System in accordance with program requirements and Department training or communication and shall maintain individual records at the Agency level for any additional documents associated with the individual seeking or enrolled in a Long-Term Services and Supports program or service.

2. The Case Manager shall use the Information Management System for purposes of documentation of all case activities, monitoring of service delivery, and service effectiveness. If applicable, the individual's Legally Authorized Representative shall be identified in the record, with a copy of appropriate documentation.

3. The Case Management Agency may accept physical or digital signatures on Department forms. If the individual is unable to sign a form requiring his/her signature because of a medical condition, any mark the individual is capable of making shall be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a Guardian or other Legally Authorized Representative shall be accepted.

4. The case records shall include:

    a. Information identifying the individual, including the individual’s state Medicaid identification number, date of birth (DOB), social security number (SSN) if applicable, address and phone number;

    b. Forms required by the Department for the specific program in which the individual is enrolled; and

    c. Documentation of all Case Management activity;

    d. Any communication accommodations necessary for the Member or Guardian.

5. The Department shall examine the Case Management Agency’s documentation practices when monitoring the Case Management Agency’s performance.

6. Records pertaining to persons seeking or receiving services shall be maintained in accordance with these rules and other applicable federal and state regulations

and accreditation standards. Where no superseding regulation or policy applies, records may be purged and destroyed per Agency policy.

7. A Case Management Agency shall designate an employee who shall be responsible for the record at all times during the examination of the record by entities other than employees of that Agency.

8. Records shall be made available for review at the Agency to authorized persons within a reasonable period of time as negotiated by the Agency and the party seeking access.

9. At no time may a person examining a record remove anything from it or otherwise make changes in it, except as delineated below:

   a. If the person seeking or receiving services, Parent of a minor, Guardian or other Legally Authorized Representative, if within the scope of his/her authority, objects to any information contained in the record, he/she may submit a request for changes, corrections, deletions, or other modifications.

   b. The person seeking or receiving services, Parent of a minor, Guardian or other Legally Authorized Representative shall sign and date the request.

   c. The Agency administrator shall make the final determination regarding the request and shall notify the requesting party of the decision.

   d. If the Agency administrator denies the request, then the requestor has the right to have a statement regarding their request entered into the record.

10. Records or portions of records may be photocopied or otherwise duplicated only in accordance with written Agency procedures, and any fee for duplication shall be reasonable pursuant to section 24-72-205, C.R.S.

11. The Case Management Agency shall provide a Member one free copy of any information contained in their record upon request.

12. The Case Management Agency shall maintain records for seven (7) years after the date a Member discharges from a waiver program, including all documents, records, communications, notes and other materials related to services provided and work performed.

8.7201.I Confidentiality of Information

1. The Case Management Agency shall protect the confidentiality of all records of individuals seeking and receiving services required by Section 26-1-114(3)(a)(I), C.R.S. and 45 C.F.R., Parts 160 and 165, Subparts A and C (HIPAA). Release of information forms obtained from the individual must be signed, dated, and kept in the Member's record. Release of information forms shall be renewed at least

annually, or with the new Provider Agency whenever there is a change of provider. Fiscal data, budgets, financial statements and reports which do not identify individuals by name or Medicaid ID number, and which do not otherwise include Protected Health Information, are subject to disclosure pursuant to the Colorado Open Records Act, Title 24, Article 72, Part 2, C.R.S.

2. Identifying information regulated by this rule is any information which could reasonably be expected to identify the individual seeking or receiving services or their Family or contact persons, including, but not limited to, name, Social Security number, Medicaid Member identification number, household number or any other identifying number or code, street address, and telephone number, photograph or digital image, or any distinguishing mark. Identifying numbers assigned and used internally within a single Agency shall be excluded from this regulation.

3. At the time of eligibility determination and enrollment, the individual, parent of a minor, Guardian and/or other person acting as an advisor to the person shall be advised of the type of information collected and maintained by the Agency, and to whom and when it is routinely disclosed.

4. This rule applies to confidential information in any format including, but not limited to, individual records, correspondence or other written materials, verbal communication, photographs, and electronically stored data.

5. The records and all other documentation or correspondence concerning individuals seeking or receiving services are the property of the Agency which is responsible for maintaining and safeguarding their contents.

6. All written authorizations referenced within this chapter must be:

    a. Signed and dated;

    b. For a specified time period;

    c. Specific as to the information or photograph or digital image to be disclosed and the intended use of such information or photograph; and,

    d. Specific as to whom it will be disclosed.

7. Authorizations may be revoked in writing or verbally at any time by the person who provided the authorization.

8. Disclosure of confidential information shall be limited to:

    a. The individual seeking or receiving services, Parent of a minor, or Guardian.

b. Persons or entities presenting written authorization signed by the person seeking or receiving services, Parent of a minor, or Guardian.

c. The Legally Authorized Representative of the person seeking or receiving services as defined in Section 8.7001.A.7, if access to confidential information is within the scope of their authority.

d. Qualified professional personnel of community centered boards, regional centers and other service agencies including boards of directors and Human Rights Committee Members to the extent necessary for the acquisition, provision, oversight, or Referral of services and supports.

e. The Department or its designees as deemed necessary by the Executive Director to fulfill the duties prescribed by Title 25.5, Article 10 of Colorado Revised Statutes.

f. To the extent necessary, qualified professional personnel of authorized external agencies whose responsibility it is to license, to accredit, to monitor, to approve or to conduct other functions as designated by the Executive Director of the Department.

g. Physicians, psychologists, and other professionals providing services or supports to a person in an emergency situation which precludes obtaining consent in such an instance:

   i. Documentation of this access shall be entered into the person's record.

   ii. This documentation shall contain the date and time of the disclosure, the information disclosed, the names of the persons by whom and to whom the information was disclosed, and the nature of the emergency.

h. The court or persons authorized by an order of the court, issued after a hearing, notice of which was given to the person, Parents of a minor or legal Guardian, where appropriate, and the custodian of the information.

i. Other persons or entities authorized by law; and,

j. The entity designated as the protection and advocacy system for Colorado pursuant to 42 U.S.C. § 604 when:

   i. A Complaint has been received by the protection and advocacy system from or on behalf of a person with a Developmental Disability; and,

   ii. Such person does not have a legal Guardian or the state or the designee of the state is the legal Guardian of such person.

9. Nothing in this regulation should be taken to mean that a person or entity who is authorized to access confidential information regarding an individual per Section 8.606.2.A is authorized to access any and all confidential information available regarding that individual. Disclosure of confidential information must be limited to the information which is necessary to perform the duties of that person or entity requiring access. The individual seeking or receiving services, Parent of a minor, or Guardian may access any and all aspects of that person's record. The Legally Authorized Representative of an individual may access those aspects of a person's record that are within the scope of their authority.

8.7201.J Preservation of Member Rights

1. Case Management Agencies shall have policies and procedures that assure the preservation of Member rights contained in Sections 25.5-10-216 through 240, C.R.S. and 8.7001.

    a. The Case Management Agency shall assure the protection of the rights of Members as defined by the Department under applicable programs, including but not limited to Section 8.7001.

    b. The Case Management Agency shall assure that the following rights are preserved for all individuals served by the Case Management Agency, whether the individual is a recipient of a state-administered program or a private pay individual:

        i. The individual and/or the individual’s Legally Authorized Representative, as necessary, is fully informed of the individual’s rights and responsibilities;

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

        iii. The individual and/or the individual’s Legally Authorized Representative selects service providers from among available qualified and willing providers;

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

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

2. Members shall have the right to read or have Case Management Agency explain any rules or regulations adopted by the Department and policies and procedures of the Case Management Agency pertaining to such persons' activities, services and supports, or to obtain copies of Title 25.5 Article 10, C.R.S., rules, policies or procedures at no cost or at a reasonable cost in accordance with Section 24-72-205, C.R.S..

3. Case Management Agencies shall inform Members, Parents of minors, Guardians and other Legally Authorized Representatives of the rights provided in Title 25.5 Article10, C.R.S., and:

    a. Case Management Agencies shall provide a written and verbal summary of rights and a description of how to exercise them, at the time of eligibility determination, at the time of enrollment, and when substantive changes to services and supports are considered through the Individualized Planning process.

    b. The information shall be provided in a manner that is easily understood, verbally and in writing, in the native language of the individual, or through other modes of communication as may be necessary to enhance understanding for the Member.

    c. Case Management Agencies shall provide assistance and ongoing instruction to Members in exercising their rights.

4. Case Management Agencies shall ensure that no individual, Member, their Family Members, Guardian or other Legally Authorized Representatives, are retaliated against in their receipt of Case Management services, direct services or supports or otherwise as a result of attempts to advocate on their own behalf.

5. Case Management Agency employees and Contractors must be made aware of the rights of Members and procedures for safeguarding these rights.

8.7201.K Member Access to Case Management Agency

1. Case Management Agencies shall have policies and procedures that assures compliance with all federally mandated requirements for access to services.

    a. In accordance with the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq. there shall be no physical or programmatic barriers which prohibit individual participation,

    b. The Case Management Agency shall not require Members to come to the Agency's office in order to receive Case Management Agency services.

    c. The Case Management Agency shall comply with nondiscrimination requirements, as defined by federal and Department rules and outlined in contract.

d. Case Management Agency functions shall be provided in a person-centered model of Case Management service delivery.

e. Case Management Agencies shall complete a Level of Care Screen when it is requested by the Member or individual in accordance with Member rights, even if the Case Management Agency staff does not believe the individual will be deemed eligible.

f. The Case Management Agency shall have office location(s) and building office hours in accordance with written requirements in Case Management Agency contract and in accordance with Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.

8.7201.L Incident Reporting

1. Case Management Agencies shall have a written policy and procedure for the timely reporting, recording and reviewing of Incidents occurring on the Case Management Agency property or care which shall include, but not be limited to:

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

   b. Serious Illnesses and injuries to a person receiving services that require intervention that is above and beyond basic first aid;

   c. Lost or missing persons receiving services;

   d. Medical emergencies involving Members that require intervention that is above and beyond basic first aid or that are not screened out by medical professionals;

   e. Hospitalization of Members;

   f. Death of Members;

   g Errors in medication administration; and,

   h. Stolen personal property belonging to a Member.

2. Reports of Incidents shall include, but not be limited to:

   a. Name of the person reporting;

   b. Name of the Member who was involved in the Incident;

   c. Name of persons involved or witnessing the Incident;

   d. Type of Incident;

   e. Description of the Incident;

f. Date and place of occurrence;

g. Duration of the Incident;

h. Description of the action taken in response to the incident;

i. Whether the Incident was observed directly or reported to the Case Management Agency;

j. Names of persons notified;

k. Follow-up action taken or where to find documentation of further follow-up; and,

l. Name of the person responsible for follow-up.

3. Case Management Agencies shall ensure all staff are trained to identify Critical Incident Reporting criteria according to the Agency's written policy and procedure and Department requirements.

4. Case Management Agencies shall ensure staff are trained to identify Incidents that are required to be reported to Colorado Department of Public Health and Environment (CDPHE).

5. Incidents meeting Critical Incident Reporting criteria, including but not limited to, Allegations of mistreatment, abuse, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported by the Case Management Agency in the Department's prescribed system within 24 hours or 1 business day of being reported.

6. The Case Management Agency shall place in the Member's record reports of Incidents not meeting Critical Incident Reporting criteria.

7. The Case Management Agency shall provide records of Incidents not meeting Critical Incident Reporting criteria to the Department upon request.

8. Case Management Agencies shall review and analyze information from Incident reports to identify trends and problematic practices which may be occurring in specific services and shall take appropriate action to report Complaints as necessary.

8.7201.M Mistreatment, Abuse, Neglect, and Exploitation

1. Pursuant to Section 25.5-10-221, C.R.S., all Case Management Agencies shall prohibit mistreatment, abuse, neglect, or exploitation of any individual and or Member.

2. Case Management Agencies shall have written policies and procedures for handling cases of alleged or suspected mistreatment, abuse, neglect, or exploitation of any individual and or Member. These policies and procedures must be consistent with state law and:

    a. Definitions of mistreatment, abuse, neglect, or exploitation must be consistent with state law and these rules;

    b. Provide a mechanism for monitoring to detect instances of mistreatment, abuse, neglect, or exploitation. Monitoring is to include, at a minimum, the review of:

        i. Incident reports;

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

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

    c. Provide procedures for reporting, reviewing, and collaborating with Adult/Child Protection Services, and law enforcement entities/representatives for investigating all allegations of mistreatment, abuse, neglect, or exploitation;

    d. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and Contractors who have engaged in mistreatment, abuse, neglect, or exploitation;

    e. Shall procure a memorandum of understanding (MOU) with local Adult/Child Protection Services, and Law Enforcement, and Provider Agencies outlining roles and responsibilities as well as outline standard practices for reporting and mitigating risk for Members.

    f. Ensure that employees and Members receiving services and Contractors are made aware of applicable state law and Agency policies and procedures related to mistreatment, abuse, neglect or exploitation;

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

    h. Require reporting of allegations within 24 hours of learning of the Incident to appropriate authorities, recording in Information Management System, reporting to the Parent of a minor, Guardian, or other Legally Authorized Representative, and Case Management Agency;

i. Require timely reporting of Critical Incident Report follow-up and reporting of actions taken by caregivers, Provider Agencies, DHS, and Law Enforcement to protect the Member receiving services. Case Management Agencies shall ensure prompt action to protect the safety, as well as, mental and physical health of the Member. Such action may include any action that would protect the Member(s) receiving services if determined necessary and appropriate by the Provider Agency or Case Management Agency pending the outcome of the investigation. Actions may include, but are not limited to, removing the Member from his/her residential and/or day services setting and removing or replacing staff;

j. Require advocating for Referral to victim support and protective orders for Members as applicable to the mistreatment, abuse, neglect, or exploitation. Provide necessary victim supports;

k. Require prompt reporting of the allegation to appropriate authorities in accordance with statutory requirements and pursuant to Section 8.7201.M.3;

l. Ensure Human Rights Committee review of all allegations; and,

m. Ensure that no individual is coerced, intimidated, threatened or retaliated against because the individual, in good faith, makes a report of suspected mistreatment, abuse, neglect or exploitation or assists or participates in any manner in an investigation of such allegations in accordance with Section 8.7201.M.3.

3. Case Management Agencies shall develop relationships with local authorities required to investigate mistreatment, abuse, neglect, and exploitation. All alleged Incidents of abuse, mistreatment, neglect, or exploitation shall be thoroughly investigated in a timely manner using the specified investigation procedures. However, such procedures must not be used in lieu of investigations required by law or which may result from action initiated pursuant to Section B, above.

a. Within 24 hours of becoming aware of the Incident, a Critical Incident report shall be made available to the Agency administrator or designee and the Case Management Agency.

b. The Agency shall maintain a written administrative record of all such investigations including:

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

ii. A summary of the investigative procedures utilized;

iii. The full investigative finding(s);

iv. The actions taken; and,

v. The Human Rights Committee review of the investigative report and the action taken on recommendations made by the committee.

c. The Agency shall ensure that appropriate actions are taken when an allegation against an employee or Contractor is substantiated, and that the results of the investigation are recorded, with the employee's or Contractor's knowledge, in the employee's personnel or Contractor's file.

8.7202 Functions of A Case Management Agency

8.7202.A Case Management Services Overview

1. Functions of the Case Manager

a. Ongoing Case Management and Targeted Case Management

b. Case management services are provided for Members and individuals accessing Home and Community-Based services. Case Management services shall include, but not be limited to, the following tasks, activities, requirements, and responsibilities:

8.7202.B Intake, Screening, and Referral

1. The Intake, Screening and Referral function of a Case Management Agency shall include, but not be limited to, the following activities:

a. The Case Management Agency shall verify the individual’s demographic information collected during the intake;

b. The completion of the Intake, Screening and Referral functions using the Department’s Information Management System to determine Applicant needs and eligibility for Long-Term Services and Supports and non- Long-Term Services and Supports services, information and Referral assistance to Long-Term Services and Supports and other services and supports, as needed;

c. Level of Care eligibility determination as applicable;

d. Referring to and facilitation of the Medicaid Financial Eligibility application process.

2. The Case Management Agency must 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 Member, individual and/or persons inquiring upon their behalf.

3. The Case Management Agency shall coordinate the completion of the Financial Eligibility determination by:

a. Verifying the individual's current Financial Eligibility status; or

b. Referring the individual to the county department of social services of the individual's county of residence for application and support with completing an application in accordance with Section 8.100.3.A.7; or

c. Providing the individual with Financial Eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides; and

d. Conducting and documenting follow-up activities to complete the Functional Eligibility determination and coordinate the completion of the Financial Eligibility determination.

4. In compliance with standards established by the Department, Case Management Agencies may ask referring agencies to complete and submit an intake and screening form to initiate the process.

   a. Case Management Agencies shall not delay the completion of an intake screen based on the use of this form.

   b. Case Management Agencies shall accept Referrals for Long-Term Services and Supports including but not limited to the following modalities:

      i. Intake Screen form

      ii. Phone calls

      iii. County DHS Referrals and communication

      iv. In person requests for Long-Term Services and Supports

      v. Medical Assistance sites

5. The Case Manager shall perform a screening to determine whether a Functional Eligibility Assessment is needed; The individual shall be informed of the right to receive an Assessment if the individual disagrees with the Case Manager's decision.

6. The Case Manager shall identify potential payment source(s), including the availability of private funding resources; including but not limited to trusts, third-party insurance, and/or private community funding.

7. The Case Manager shall implement the use of a Case Management Agency procedure for prioritizing urgent inquiries.

8. When an individual with Intellectual and Developmental Disabilities cannot be safely served in a community setting due to challenging behavior, including

behavior that presents a danger to self or others, or behavior which results in significant property destruction and community placement options have been unsuccessful and exhausted, the Case Management Agency shall make a Referral to the Regional Centers and shall comply with the Regional Centers admission policy.

8.7202.C Nursing Facility Admission and Discharge

1. For Members in HCBS Programs who are already determined to be at the nursing facility Level of Care and seeking admission into a nursing facility, the Case Management Agency shall:

    a. Provide information about community-based services to the individual to determine if they desire to live in the community with additional support and if the individual indicates interest to live in the community, document preference in the Department's Information Management System.

    b. Coordinate the admission date with the facility.

    c. Complete the Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen, and if there is an indication of a mental illness or Developmental Disability, submit to the Department or its agent to determine whether a Pre-Admission Screening and Resident Review (PASRR) Level 2 evaluation is required.

    d. Maintain the Level 1 Screen in the individual's case file regardless of the outcome of the Level 1 Screen; and

    e. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the most recent Level of Care screen is not six (6) months old or older.

2. The Case Manager and the nursing facility shall complete the following activities for discharges from nursing facilities:

    a. The nursing facility shall contact the Case Management Agency in the district where the nursing facility is located to inform the Case Management Agency of the discharge if placement into home or community-based services is being considered.

    b. The nursing facility and the Case Management Agency Case Manager shall coordinate the discharge date.

    c. When placement into HCBS Programs is being considered, the Case Management Agency shall determine the remaining length of stay.

i. If the end date for the nursing facility is indefinite, the Case Management Agency shall assign an end date not beyond one (1) year from the date of the most recent Level of Care Screen.

ii. If the Level of Care Screen was conducted within the preceding twelve (12) months, the Case Management Agency shall generate a new certification page that reflects the end date that was assigned to the nursing facility.

iii. If no Level of Care Screen was completed within the preceding twelve (12) months, the Case Management Agency shall complete a new Level of Care Screen. The Assessment results shall be used to determine Level of Care and the new length of stay.

iv. The Case Management Agency shall send a copy of the Level of Care Screen certification page to the eligibility enrollment specialist at the county department of social services.

v. Within 2 business days of financial approval, the Case Management Agency shall outreach the Member to review available service options.

vi. The Case Management Agency shall submit the HCBS Prior Authorization Request to the Department or its fiscal agent.

3. If the individual is being discharged from a hospital or other institutional setting, the discharge planner shall contact the Case Management Agency for Assessment by emailing or faxing the initial intake and screening form.

4. The Case Manager shall view and document the current Personal Care Boarding Home license, if the individual lives, or plans to live, in a Congregate Facility as defined at Section 8.7100.A.12..

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

6. If the individual has been evaluated with the Level of Care Screen and has been assigned a length of stay that has not lapsed, the Case Management Agency Case Manager is not required to conduct another review when the transition is requested unless a change in condition has occurred since the most recent Level of Care Screen.

8.7202.D Determination of Developmental Delay and Intellectual and Developmental Disability

1. A determination of developmental delay or intellectual and developmental disability does not constitute a determination of eligibility for services or supports. The Case Management Agency shall determine whether a person has a developmental delay or intellectual and developmental disability and, therefore, may be eligible to receive services and supports pursuant to Sections 25.5.6-1702(3) and 1704, C.R.S., in accordance with criteria prescribed by the Department.

2. Eligibility for Medicaid funded programs specific to persons with developmental delays or intellectual and developmental disabilities shall be determined pursuant to the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 C.C.R. 2505-10 Section 8.100).

3. The developmental delay or intellectual and developmental disability determination shall be made by case management agency staff having the minimum qualifications outlined in 10 CCR 2505-10 Section 8.7203.A(1)-(5)

4. A Request for Developmental Disability Determination of a developmental delay or intellectual and developmental disability shall be submitted to the Case Management Agency in the defined service area where the person resides, including temporary residences, such as incarceration, hospitalization, or foster care placement within the state, in the form and manner prescribed by the Department.

5. At the time of request, the Case Management Agency shall:

    a. Provide the applicant with all required forms and a list of the minimum required documents and information necessary for the determination of intellectual or developmental disability or developmental delay determination; and,

    b. Provide the applicant with information on where to obtain testing for the level of intellectual functioning and adaptive behavior, if requested. The responsibility for obtaining such assessments shall be with the applicant, parent(s) of a minor and/or legally authorized representative.

6. The applicant, parent(s) of a minor and/or legally authorized representative shall provide all documentation and information necessary for the determination of developmental delay or intellectual and developmental disability within ninety (90) calendar days of the request.

    a. The Case Management Agency may request additional documentation and/or information, as needed, to complete the determination of developmental delay or intellectual and developmental disability.

b. The applicant, parent(s) of a minor and/or legally authorized representative may have additional assessments completed and submitted to the Case Management Agency for consideration.

7. If the applicant, parent(s) of a minor and/or legally authorized representative has not provided the documentation and information necessary for the determination within ninety (90) calendar days of the request, the Case Management Agency shall:

   a. Close the request and notify the applicant in writing according to the procedures established at Section 8.7202.D(13); or,

   b. The Case Management Agency may, at the request of the applicant, parent of a minor and/or legally authorized representative extend the deadline for providing the necessary documentation and information by up to an additional ninety (90) calendar days.

      i. In no case shall the deadline for providing the necessary documentation and information exceed one hundred eighty (180) calendar days.

      ii. The Case Management Agency shall provide a written update to the applicant no less than every ninety (90) calendar days until a determination of developmental delay or intellectual and developmental disability is completed or the request is closed.

      iii. If the extended deadline for providing the necessary documentation and information has expired and there is still insufficient information to make a determination of developmental delay or intellectual and developmental disability, the Case Management Agency shall close the request and notify the applicant and/or legally authorized representative in writing according to the procedures established at Section 8.7202.D(13).

8. For all applicants, the Case Management Agency shall enter into the Department's prescribed Information Management System and shall permanently maintain a written and/or electronic record of the developmental delay or intellectual and developmental disability determination in a form and manner prescribed by the Department. The record, at a minimum, shall include:

   a. The name of the applicant;

   b. The applicant's date of birth;

   c. The date of the determination of developmental delay or intellectual and developmental disability; and

d. A description of the rationale for the developmental delay or intellectual and developmental disability determination including, at minimum, assessment scores and diagnoses;

9. All information and assessments used to determine a developmental delay or intellectual and developmental disability shall be current so as to accurately represent the applicant's abilities at the time of determination.

a. Assessments of adaptive behavior shall have been completed within three (3) years of the request.

b. Assessments of intellectual functioning shall have been completed as follows:

i. If an individual is between five (5) and eighteen (18) years of age, at least one intellectual assessment shall have been completed to determine the individual's impairment of general intellectual functioning; or,

ii. If an individual is eighteen (18) years of age or older and there is only one intellectual assessment available to determine the individual's impairment of general intellectual functioning, the assessment shall have been completed when the individual was at least eighteen (18) years of age and shall have been completed within ten (10) years of the request; or,

iii. If there is historical pattern of consistent scores, based on two (2) or more intellectual assessments, that demonstrate an impairment of general intellectual functioning, the assessments may be used regardless of the individual's age at the time of determination.

c. An established neurological condition shall be documented as follows:

i. A diagnosed neurological condition shall be determined by a MD, DO, PA, APN, psychologist, neuropsychologist, or other qualified medical professional practicing within the scope of their license; or,

ii. If a specific diagnosis is not possible, a written statement from a MD, DO, PA, APN, psychologist, neuropsychologist, or other qualified medical professional, practicing within the scope of their license, may be used as long as there is a documented effort to determine a diagnosis and the available assessment information reasonably supports a conclusion that a neurological impairment is present.

iii. The effects of mental illness or physical or sensory impairment must be considered to determine the extent to which such

impairments are the sole contributing factor to the impairment of general intellectual functioning or limitations to adaptive behavior.

iv. The established neurological condition documentation must be signed by the MD, DO, PA, APN, psychologist, neuropsychologist, or other qualified medical professional practicing within the scope of their license.

10. The Case Management Agency shall make the determination of developmental delay or intellectual and developmental disability within thirty (30) calendar days of the receipt of all information and documentation required to make a determination.

11. The date of the developmental delay or intellectual and developmental disability determination shall be the date that all documentation and information required for the determination of a developmental or intellectual and developmental disability was received by the Case Management Agency.

12. If a delay to the determination of a developmental delay or intellectual and developmental disability is due to the actions or inactions of the Case Management Agency, the original date of request shall be used.

13. The Case Management Agency making the developmental delay or intellectual and developmental disability determination shall, in writing, notify the applicant, parent(s) of a minor and/or their legally authorized representative, and other such persons as designated by the applicant, of the decision. Such notification shall:

    a. Be mailed to the person within seven (7) calendar days of the date of determination decision;

    b. Be provided in such alternative means of communication as to reasonably ensure that the information has been communicated in an understandable form; and,

    c. For persons determined to have a developmental delay or intellectual and developmental disability, contain an explanation of the process that will occur -and notice that, at a minimum, a Person-Centered Support Plan shall be developed upon enrollment into a developmental disability program;

    d. For persons determined not to have a developmental delay or intellectual and developmental disability or persons whose request is closed without the determination of a developmental delay or intellectual and developmental disability, state the reasons for the determination or closure, and provide a written Long-Term Care Notice of Action form in accordance with the provisions of Section 8.057 regarding the applicant's right to appeal the decision to the Office of Administrative Courts.

14. Applicants determined not to have a developmental delay or intellectual and developmental disability may request a new determination at any time upon receipt of new or missing required information, and a new request date shall be established.

15. A determination of developmental delay or intellectual and developmental disability shall be accepted by other Case Management Agencies, service agencies and regional centers.

16. A determination of developmental delay or intellectual and developmental disability shall be permanent and shall not require renewal or review unless:

    a. The Member Identified Team determines that developmental disability services are no longer needed due to improvement in a person's condition and recommends a redetermination; or,

    b. Information from a new evaluation becomes available which demonstrates sufficient improvement in a person's condition such that the determination should be reviewed.

8.7202.E Level of Care Determination

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

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

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

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

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

    c. For a resident who is being admitted to the nursing facility from the hospital, the Case Management Agency shall complete and document the

Assessment, including a Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen within two (2) working days after notification.

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

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

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

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

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

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

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

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

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

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

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

e. For HCBS Programs and admissions to nursing facilities from the community, the original Level of Care Screen and Person-Centered Support Plan copy shall be sent to entities or persons of the Member's choosing. If changes to the individual's condition occur which significantly change the payment or services amount, a copy of the Person-Centered Support Plan must be sent to the Provider Agency, and a copy is to be maintained in the Member's record.

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

8. The Case Management Agency shall conduct the following activities at the conclusion of the Level of Care Screen for nursing facility admission if the individual expresses a desire to live in, or does not oppose to living in the community with additional support:

a. Complete the Rapid Reintegration Barrier Questions within the Department's Prescribed System at the completion of the Level of Care Screen.

i. If the Member is determined to have unstable housing, additional support needed beyond a thirty (30) day resolution, or transition support is needed, the Case Manager will complete a Rapid Referral to the Transition Coordination Agency within two (2) business days from completion of the level of care.

ii. If the Member has HCBS, stable housing, no transition support is needed, and is able to transition to the community within thirty (30) days, the Case Manager will complete the Rapid Reintegration Plan. The Rapid Reintegration Plan will consist of a series of questions that will identify any additional support that can be resolved by the case manager, the date on which the reintegration is intended to occur and updated to include the date the reintegration occurred once completed.

b. Refer the Member/ Individual to community resources, as needed.

c. If the individual does not meet financial eligibility requirements, the Case Manager will submit an escalation ticket to Transition Escalation as instructed by the Department.

d. If the Member declines a referral to the Transition Coordination Agency or Rapid Reintegration Plan, the Case Manager shall:

i. advise the Member to follow the nursing facility transition process;

ii. educate the Member about In Reach counseling, if they become interested in living in the community in the future; and document in the Departments Information Management System the reason for declination. Once documented, the Rapid Reintegration Plan stops and is no longer applicable.

e. For any Member that goes through the Rapid Reintegration process, the Case Manager will complete a post reintegration survey with the Member at their next contact or within ninety (90) days, this is the final step in the Rapid Reintegration process.

f. If a Member transitioned from the Nursing Facility to the community or they request to end the Rapid Reintegration Plan, the Case Manager will close the Rapid Reintegration plan in the Department's Prescribed System.

8.7202.F Needs Assessment

1. Needs Assessment

a. The Case Manager shall continually identify individuals' strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of Critical Incidents.

b. The Case Manager shall complete a new Level of Care Screen during an in-person Reassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the Long-Term Services and Supports Program in which the individual is enrolled. Upon Department approval, Reassessment may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g., natural disaster, pandemic, etc.).

2. Reassessment

a. The Case Manager shall commence a regularly scheduled Reassessment at least one (1) but no more than three (3) months before the required completion date. The Case Manager shall complete a Reassessment of a Member within twelve (12) months of the initial individual assessment or the most recent Reassessment. A Reassessment shall be completed within 10 days if the individual's condition changes or if required by program criteria.

b. The Case Manager shall update the information provided at the previous Level of Care Screen in the Department prescribed system within five business days of completion of the Assessment.

c. Reassessment shall include, but not be limited to, the following activities:

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

ii. Review Person-Centered Support Plan, service agreements and provider contracts or agreements;

iii. Evaluate effectiveness, appropriateness and quality of services and supports;

iv. Verify continuing Medicaid eligibility, other financial and program eligibility;

v. Annually, or more often if indicated, complete a new Person-Centered Support Plan and service agreements;

vi. Inform the individual's medical provider of any changes in the individual's needs;

vii. Maintain appropriate documentation, including type and frequency of Long-Term Services and Supports the individual is receiving for certification of continued program eligibility, if required by the program;

viii. Refer the individual to community resources as needed and develop resources for the individual if the resource is not available within the individual's community; and

ix. Submit appropriate documentation for authorization of services, in accordance with program requirements.

x. In order to assure quality of services and supports and the health and welfare of the individual, the Case Manager shall ask for permission from the individual to observe the individual's residence as part of the Reassessment process, but this shall not be compulsory of the individual.

d. The Case Management Agency shall be responsible for completing Reassessments of Members receiving care in a nursing facility. A Reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a Reassessment or if the Case Manager assigns a definite end date. The nursing facility shall be responsible to send the Case Management Agency a Referral for a new Assessment as needed. At the time of completing the Reassessment, unless the individual opposes community living, the Case Manager shall provide options counseling on community-based services to the individual to determine if they desire to live in the community with additional support.

8.7202.G Waitlist Management

1. When the total capacity for enrollment or the total appropriation authorizations by the Colorado General Assembly has been met, the Department shall maintain one statewide waiting list for individuals eligible for the HCBS-DD waiver.

    a. The Department of Health Care Policy and Financing shall maintain at least two categories of the one waitlist to include statuses of: As Soon As Available or Safety Net.

        i. As Soon As Available (ASAA) means the individual has requested enrollment as soon as available.

        ii. Safety Net (SN) means the individual does not currently need or want adult services, but requests to be on the waiting list in case a need arises. This category includes individuals who are not yet eligible for adult programs due to not having reached their 18th birthday.

    b. Date Specific in a waitlist means the individual does not need services at this time but has requested enrollment at a specific future date. This category includes individuals who are not yet eligible for adult programs due to not having reached their 18th birthday.

2. The name of an individual eligible for the HCBS-DD waiver program shall be placed on the waiting list by the Case Management Agency making the eligibility determination if the Member meets DD waiver target criteria.

3. When an individual is placed on the waiting list for HCBS-DD Waiver Services, a written Notice of Action shall be sent to the individual or the individual’s legal Guardian that includes information regarding individual rights and the Member’s right to appeal pursuant to Section 8.057 et seq.

4. The placement date used to establish an individual’s position on a waiting list shall be:

a. The date on which the individual was initially determined to have a Developmental Disability by the Case Management Agency; or

b. The fourteenth (14) birth date if a child is determined to have a Developmental Disability by the Case Management Agency prior to the age of fourteen.

5. As openings become available in the HCBS-DD Waiver program in a Defined Service Area, that Case Management Agency shall report that opening to Health Care Policy and Financing.

6. Individuals whose names are 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:

a. An emergency situation where the health and safety of an individual or others is endangered, and the emergency cannot be resolved in another way and if the individual meets DD waiver Target Criteria. Individuals at risk of experiencing an emergency are defined by the following criteria:

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

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

iii. Danger to others: the individual's behavior or psychiatric condition is such that others in the home are at risk of being hurt by the individual and sufficient supervision to ensure safety of the individual in the community cannot be provided by the current caretaker.

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

v. Loss or Incapacitation of Primary Caregiver: the individual’s primary caregiver is no longer in the individual’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 individual 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 individual's health and welfare.

7. Enrollments are reserved to meet statewide priorities that may include:

   a. An individual 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,

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

   c. Members enrolled in a Home and Community-Based Services CES or CHRP waivers who are under 18 years of age and are eligible for the HCBS-DD waiver.

   d. Individuals who are in an emergency situation.

8. Enrollments shall be authorized for individuals based on the criteria set forth by the General Assembly in appropriations when applicable.

   a. An individual shall accept or decline the offer of enrollment within 30 calendar days from the date the enrollment was offered. Reasonable effort, such as a second notice or phone call, shall be made to contact the individual, family, legal Guardian, or other interested party.

   b. Upon a written request of the individual, family, legal Guardian, or other interested party the Case Management Agency may grant an additional 30 calendar days to accept or decline an enrollment offer. The delineation reason shall be recorded in the Department's Information Management System within 10 business days.

   c. If an individual does not respond to the offer of enrollment within the time set forth in subsection 2 and/or 3 above, the offer is considered declined and the individual shall maintain their position on the waiting list as determined by their placement date but will be moved to safety net status until the Member is willing or able to accept an enrollment. The Member may notify their Case Management Agency of their desire to move back to a status of As Soon As Available (ASAA) when they would be ready to accept an enrollment into the DD waiver.

d. The Case Management Agency shall record all waiting list communications, enrollments, and declinations in the Department's Information Management System within 10 business days.

e. The Case Management Agency shall record an annual waiting list review within the Department's Information Management System within 10 business days or as directed by the Department.

8.7202.H Telehealth and Delivery

1. Members eligible to use HCBS Telehealth are those enrolled in the waivers and services as defined in this rule at Section 8.7100.

2. The Case Management Agency shall ensure the use of HCBS Telehealth is the choice of the Member through the Person-Centered Support Planning process by indicating the Member's choice to receive HCBS Telehealth in the Department prescribed IT system.

3. Through the Person-Centered Support Planning process, the Case Management Agency shall identify and address the benefits and possible detriments to Members choosing to use HCBS Telehealth for service delivery.

4. HCBS Telehealth delivery must be prior authorized and documented in the Member's Person-Centered Support Plan.

5. Telehealth as a service delivery method for authorized HCBS Waiver Services, shall not interfere with any individual rights or be used as any part of a Rights Modification plan.

8.7202.I Utilization Review

1. The Case Manager shall complete a Utilization Review at quarterly monitoring and as needed.

2. The Case Manager shall immediately report, to the appropriate Agency, any information which indicates an overpayment, incorrect payment or mis-utilization of any public assistance benefit and shall cooperate with the appropriate Agency in any subsequent recovery process, in accordance with Section 8.076.

8.7202.J Person-Centered Support Coordination

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

a. The Member shall designate a Member Identified Team which may include but not be limited to: a LTSS Representative, family members, or

individuals from public and private agencies to the extent such partnership is requested by the Member.

2. Service and support coordination shall assist the Member Determine the individual's functional capacity to ensure:

   a. A Person-Centered Support Plan is developed, utilizing necessary information for the preparation of the Person-Centered Support Plan and using the Member Identified Team process;

   b. Facilitating access to and provision of services and supports identified in the Person-Centered Support Plan;

   c. The coordination and continuity of services and supports identified in the Person-Centered Support Plan for continuity of service provision; and

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

3. Person-Centered Support Plan Development

   a. The Case Manager shall work with individuals to design and update Person-Centered Support Plans that address individuals' goals and assessed needs and preferences;

   b. The Case Manager shall share a copy of the completed Person-Centered Support Plan with all providers that are providing services under the plan within 15 working days after the plan is completed or updated.

4. Remediation

   a. The Case Manager shall identify, resolve, and to the extent possible, establish strategies to prevent Critical Incidents and problems with the delivery of services and supports.

5. The Case Manager shall develop the Person-Centered Support Plan for individuals not residing in nursing facilities within fifteen (15) working days after determination of program eligibility.

6. The Case Manager shall:

   a. Address the functional needs identified through the individual Assessment in the Person-Centered Support Plan;

b. Offer informed choices to the individual regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but that may not be available;

c. Support Members in provider selection to the degree and extent that the Member or Family requests or requires for successful placement with a direct service provider;

d. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

e. Reflect cultural considerations of the individual and be conducted by providing information in Plain Language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency;

b. Formalize the Person-Centered Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;

c. Contain prior authorization for services, in accordance with program directives;

d. Contain prior authorization of Adult Long-Term Home Health Services, pursuant to Sections 8.520.8;

e. Include a method for the individual to request updates to the plan as needed;

f. Include an explanation to the individual of procedures for lodging Complaints against Case Management Agencies and providers;

g. Include an explanation to the individual of Critical Incident procedures; and

h. Explain the appeals process to the individual.

7. The Case Manager shall provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and shall ensure that the development of the Person-Centered Support Plan:

a. Occurs at a time and location convenient to the Member;

b. Is led by the individual, the individual's Parent's (if the individual is a minor), and/or the individual's Legally Authorized Representative;

c. Includes people chosen by the individual;

d. Addresses the goals, needs and preferences identified by the individual throughout the planning process;

e. Includes the arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the individual regarding service provision and formalizing provider agreements in accordance with program rules; and

f. Includes Referral to community resources as needed and development of resources for the individual if a resource is not available within the individual's community.

8. Prudent purchase of services:

a. The Case Manager shall arrange services and supports using the most cost-effective methods available in light of the individual's needs and preferences.

b. When family, friends, volunteers or others are available, willing and able to support the individual at no cost, these supports shall be utilized before the purchase of services, providing these services adequately meet the individual's needs.

c. When public dollars must be used to purchase services, the Case Manager shall encourage the individual to select the lowest-cost provider of service when quality of service is comparable.

d. The Case Manager shall assure there is no duplication in services provided by Long-Term Services and Supports programs and any other publicly or privately funded services.

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

10. Case Managers shall follow all documented rules, regulations, policies and operational guidance in these rules and set forth by the Department for Case Management and Home and Community-Based Services.

11. Case Managers shall support Members in identifying qualified Provider Agencies and assist them in determining the best fit for their needs and service plan approvals, including but not limited to: setting up tours, communicating with potential providers about the Member's needs or soliciting entrance to programs on behalf of the Member, depending on Member preferences and needs.

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

    a. Home modification

    b. Vehicle modification

    c. Organized Health Care Delivery System

    d. Consumer-Directed Attendant Supports Services

    e. In-Home Support Services

    f. Nursing Facilities

    g. Transition Services

    h. Long Term Home Health

    i. Private Duty Nursing

8.7202.K Monitoring

1. Case Management Agencies shall be responsible to monitor the overall provision of services and supports authorized by Case Managers to ensure the rights, health, safety and welfare of Members, quality services, and that service provision practices promote Member's ability to engage in self-determination, self-representation, and self-advocacy. Monitoring is required for all waivers in accordance with federal waiver requirements and §§ 25.5-6-1701 — 25.5-6-1709. §§ 25.5-6-1702(3)

2. Monitoring activities shall include but not be limited to the following:

    a. Case Managers shall monitor service providers and the delivery of services and supports identified within the Person-Centered Support Plan and the Prior Authorization Request (PAR) for potential rights violations, risks to health, safety and welfare; changed needs, issues with utilization or provision of services, quality of service deliver, or issues with statutory or legal compliance. This may include, but is not limited to:

        i. Reviewing and following up on Incident reports, individualized service plans, Rights Modifications, and other provider documentation

        ii. Observing the environment(s) where services are being provided

        iii. Contacting Provider Agency staff about service provision and Member satisfaction

iv. Contacting Members and/or their Legally Authorized Representative about service provision and Member satisfaction

b. The Case Manager shall contact service provider(s) to perform monitoring no less frequently than every 6 months.

c. The Case Manager shall, at a minimum, perform quarterly monitoring contacts with the Member, as defined by the Member's certification period start and end dates.

i. At a minimum, Member monitoring contacts shall include the following:

1) A review of the Member's Level of Care Screen, Needs Assessment and Person-Centered Support Plan, with the Member, to determine whether their Level of Care or needs have changed, or needs are not being met.

2) A review of the Member's service utilization to determine whether services are being delivered/utilized as outlined in the Person-Centered Support Plan /Prior Authorization Request (PAR).

3) An evaluation of the Member's satisfaction with services, to include whether service provision practices promote self-determination, self-representation, and self-advocacy and are person-centered.

4) An evaluation of the Member's health, safety and welfare, including respect for individual rights.

5) A review of the Member's goals, choices and preferences

a) An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period not to include the annual Long-Term Services and Supports Level of Care Reassessment. The Case Manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services. Case Managers shall contact service providers and Members to coordinate the monitoring.

ii. The Case Manager shall contact service provider(s) to perform monitoring no less frequently than every six (6) months.

iii. Upon Department approval in advance, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods.

iv. Such approval may be granted for situations in which in- person face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g. natural disaster, pandemic, etc.).

1) The Case Manager shall perform three monitoring contacts each certification period in addition to the one required in-person monitoring. The three additional monitoring contact shall be either in-person, on the phone, or through other technological modality based on the Member preference of engagement. Additional monitoring contacts may also be performed based on any Critical Incident Reports or other needs that arise throughout the service plan year.

v. Contacts shall be directly with the Member and/or their Legally Authorized Representative.

vi. Contacts shall be bidirectional, i.e., questions and responses, conversation between the Case Manager and the Member and/or their Legally Authorized Representative; letters, emails or voicemails to the Member and/or their Legally Authorized Representative shall not constitute a monitoring contact for purposes of this requirement.

3. The Case Manager shall take appropriate action to remediate any risks or issues identified during monitoring activities regarding the rights, health, safety and welfare of the Member or service provision or utilization.

a. The identified issue(s) shall be documented in the Information Management System.

b. The action(s) taken to remediate identified issue(s) shall be documented in the Information Management System.

4. The following criteria may be used by the Case Manager to determine the individual's level of Case Management involvement needed:

a. Member preference;

b. Availability and level of involvement of family, volunteers, or other supports;

c. Overall level of physical capabilities;

d. Mental status or cognitive capabilities;

e. Duration of disabilities or conditions;

f. Length of time supports have been in place;

g. Stability of providers/unpaid supports;

h. Whether the Member is in a Crisis or acute situation;

i. The Member's perception of need for services;

j. The Member's familiarity with navigating the system/services;

k. The Member's move to a new housing alternative; and

l. Whether the individual was discharged from a hospital or Nursing Facility.

8.7202.L Critical Incident Reporting

1. Case Managers shall report Critical Incidents within 24 hours of notification within the Information Management System.

2. Critical Incident reporting is required when the following occurs

   a. Injury/Illness;

   b. Missing Person;

   c. Criminal Activity;

   d. Unsafe Housing/Displacement;

   e. Death;

   f. Medication Management Issues;

   g. Other High-Risk Issues;

   h. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;

   i. Damage to the Consumer's Property/Theft.

3. 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.

4. Case Managers shall comply with mandatory reporting requirements set forth at Sections 18-6.5-108, 19-3-304, and 26-3.1-102, C.R.S.

5. Each Critical Incident Report must include:

a. Incident type

i. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, 26-3.1-101, 16-22-102 (9), and 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.

6. The Case Manager shall complete required follow up activities and reporting in the Information Management System within assigned timelines.

7. The Case Manager shall be responsible to report suspected crimes against a Member to protective services. In the event, at any time throughout the Case Management process, the Case Manager suspects an individual to be a victim of mistreatment, abuse, neglect, exploitation or a harmful act, the Case Manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence and/or the local law enforcement agency. The Agency shall ensure that employees and Contractors obligated by statute, including but not limited to, Section 19-13-304, C.R.S., (Colorado Children's Code), Section 18-6.5-108, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Section 26-3.1-102, C.R.S., (Human Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

8.7202.M Case Management Agency Transfers

1. Case Management Agencies shall complete the following procedures in the event a Member transfers from one Case Management Agency Defined Service Area to another Case Management Agency Defined Service Area.

2. Transfer activities shall include, at minimum,

a. Initial contact by the originating Case Management Agency with the receiving Case Management Agency in the Case Management Agency Defined Service Area of the Member.

b. Determination of transfer date.

i. Determination of transfer date shall not be delayed based on receipt of mailed, electronic, or paper records.

c. Necessary access and permissions in all appropriate Department prescribed systems.

d. Both agencies, sending and receiving, must verify and document transfer request sent and transfer request received.

e. All transfer activities shall be documented and recorded in the Department's prescribed system.

f. The originating Case Management Agency shall notify the originating county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and the eligibility enrollment specialist shall comply with the transfer requirements set forth in Section 8.100.3.C. The receiving Case Management Agency shall coordinate the transfer with the eligibility enrollment specialist of the receiving county.

3. The transferring Case Management Agency shall contact the receiving Case Management Agency by telephone or email and give notification that the individual is planning to transfer, negotiate a transfer date and provide all information necessary to ensure that the receiving Case Management Agency is able to meet the individual's needs.

4. Both agencies, sending and receiving, shall verify and document the transfer request sent and transfer request received.

5. The transferring Case Management Agency shall notify the originating county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and eligibility enrollment specialist shall follow rules described in Section 8.100.3.C. The receiving Case Management Agency shall coordinate the transfer with the eligibility enrollment specialist of the new county.

6. Prior to transfer, the transferring Case Management Agency shall make available to the receiving Case Management Agency the individual's case records in the Information Management System.

7. If the individual is moving from one Case Management Agency Defined Service Area to another Case Management Agency Defined Service Area to enter an

Alternative Care Facility or Nursing Facility, the transferring Case Management Agency shall forward copies of the individual's records to the facility prior to the individual's admission to the facility, in accordance with Section 8.7202.M.

8. To ensure continuity of services and supports, the originating Case Management Agency and the receiving Case Management Agency shall coordinate the arrangement of services prior to the individual's relocation to the receiving Case Management Agency's defined service area and within ten (10) working days after notification of the individual's relocation.

9. If a failure of Case Management Agency transfer results in a break in payment authorization, the Case Management Agencies shall be subject to Payment Liability as outlined in 10 CCR 2505-10 8.7202.Z.

10. The receiving Case Management Agency shall complete a face-to-face meeting with the individual in the individual's residence and a case summary update within ten (10) working days after the individual's relocation, in accordance with Assessment procedures for individuals served by Case Management Agencies. Upon Department approval, the meeting may be completed using virtual technology methods or may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the Case Manager or individual (e.g., natural disaster, pandemic, etc.)

11. The receiving Case Management Agency shall review the Person-Centered Support Plan and the Level of Care Screen and change or coordinate services and providers as necessary. The originating Case Management Agency shall not close out the case until face-to-face contact is verified.

12. If indicated by changes in the Person-Centered Support Plan, the receiving Case Management Agency shall revise the Person-Centered Support Plan and prior authorization forms as identified during the review.

13. Within thirty (30) calendar days of the individual's relocation, the receiving Case Management Agency shall forward to the Department, or its fiscal agent, revised forms as required by the Member's approved publicly funded program(s).

8.7202.N Case Management Agency Member Exceptions Process

1. Members, and their Legally Authorized Representative, may request to be served by a Case Management Agency outside of their defined service area with the approval of the Case Management Agency outside their defined service area and Department oversight.

2. The Case Management Agency must be willing and able to incur all costs to meet all regulatory and contractual requirements for the Members served outside their defined service areas. The Department does not provide additional funding for any travel costs incurred by a Case Management Agency that is serving a

Member enrolled in any HCBS Waiver or State General Fund programs outside of the Agency's approved Defined Service Area.

3. The Case Management Agency must be willing and able to perform monitoring and follow up in the same manner and frequency as required for a Member within the defined service area. The Department shall not allow an exception to in-person Assessments or monitoring visit requirements based solely on travel time.

4. Case Management Agency policies and procedures must outline how the Case Management Agency plans to ensure all regulatory and contractual requirements can be met for Members receiving Case Management services from a Case Management Agency outside their defined service area.

5. The Case Management Agency shall follow the process approval and reporting requirements set forth by the Department for Members being served outside their defined service area.

6. If a person requires a transfer to a new Case Management Agency for any reason, both Case Management Agencies must follow the transfer process in Section 8.7202.M to maintain Member eligibility and services.

7. Case Management Agencies shall have a policy and procedure to grant Members a choice of Case Manager at their Agency.

8.7202.O State General Fund Transfers

1. When an individual enrolled in, or on the waiting list for, State General Fund program and moves to another Case Management Agency’s defined service area and wishes to transfer their State General Fund program, the following procedure shall be followed:

2. All transfer activities outlined in 8.7202.M shall apply to State General Fund Programs.

    a. The originating Case Management Agency shall send the State General Fund Individual Person-Centered Support Plan to the receiving Case Management Agency, where the receiving Case Management Agency shall determine if appropriate State General Fund funding is available or if the individual will need to be placed on a waiting list by reviewing the State General Fund Individual Person-Centered Support Plan in the Department’s prescribed system. The receiving Case Management Agency decision of service availability will be communicated in the following way:

    b. The receiving Case Management Agency shall notify the individual seeking transfer of its decision by the individual’s preferred method, no later than ten (10) business days from the date of the request; and

c. The receiving Case Management Agency shall notify the originating Case Management Agency of its decision by U.S. Mail, phone call or email of its decision no later than ten (10) business days from the date of the request.

i. The decision shall clearly state:

1) The receiving Case Management Agency's decision

2) The basis of the decision; and

3) The contact information of the assigned Case Manager or waiting list manager.

ii. The originating Case Management Agency shall contact the individual requesting the transfer no more than 5 days from the date the decision was received to:

1) Ensure the individual understands the decision; and

2) Support the individual in making a final decision about the transfer.

d. After the transfer, there shall be a transfer meeting in-person when possible, or by phone if geographic location or time does not permit, within fifteen (15) business days of when the notification of service determination is sent out by the receiving Case Management Agency. The transfer meeting must include but is not limited to the transferring individual and the receiving Case Manager. Any additional attendees must be approved by the transferring individual.

e. The receiving Case Management Agency must ensure that:

i. The transferring individual meets his or her primary contact of the receiving Case Management Agency.

ii. The individual is informed of the date when Services and Supports will be transferred, when Services and Supports will be available, and the length of time the Supports and Services will be available.

iii. The receiving Case Management Agency Case Manager shall have an in-person meeting with the individual to review and update the Person-Centered Support Plan, prior to the Supports and Services being authorized. Upon Department approval, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g. natural disaster, pandemic, etc.).

8.7202.P Informed Consent for Rights Modifications

1. The Case Manager is responsible for following the HCBS Settings Final Rule, as codified at Section 8.7001.B, and shall ensure compliance with all requirements of Section 8.7001.B, and shall obtain, maintain, and distribute a signed Informed Consent for any Rights Modification pursuant to Section 8.7001.B.4 per Department requirements as set forth in rule, other issuances, and trainings.

2. The Case Manager shall arrange for meetings to discuss proposed Rights Modifications consistent with the timelines in Sections 8.7001.B.4.g-h..

3. Before requesting or obtaining Informed Consent, the Case Manager shall make the offers required under 8.7001.B.4.d.i to the Member and record the Member's responses in the Department prescribed Information Management System.

4. The Case Management Agency's Case Manager is responsible for obtaining Informed Consent and other documentation supporting any Rights Modifications, maintaining these materials in the prescribed Department system as a part of the Person-Centered Support Plan, and distributing them to any providers implementing the Rights Modifications.

8.7202.Q Human Rights Committees

1. Each Case Management Agency shall establish at least one Human Rights Committee (HRC) as a third party mechanism to safeguard the rights of members in waivers targeted to individuals with Intellectual and Developmental Disabilities. The Human Rights Committee is an advisory and review body to the administration of each Case Management Agency.

2. The Human Rights committee shall be constituted as required by Section 25.5-10-209(2)h, C.R.S.

3. If a consultant to the Case Management Agency, regional center, or Provider Agency serves on the Human Rights Committee, procedures shall be developed related to potential conflicts of interest.

4. The Case Management Agency shall orient members regarding the duties and responsibilities of the Human Rights Committee.

5. The Case Management Agency shall provide the Human Rights Committee with the necessary staff support to facilitate its functions.

6. Each Provider Agency shall make referrals as required in rules and regulations for review by the Human Rights Committee(s) in the manner required by Department.

7. The recommendations of the Human Rights Committee shall become a part of the Case Management Agency's record as well as a part of the individual's master record.

8. The Human Rights Committee shall develop operating procedures which include, but are not limited to, Human Rights Committee responsibilities for the committee's organization, Department required universal documents, the review process, mitigation of potential conflicts of interest, and provisions for recording dissenting opinions of committee members in the committee's recommendations.

9. The Human Rights Committee shall establish and implement operating and review procedures to determine that the practices of the Case Management Agency is in compliance with Section 25.5-10, C.R.S., are consistent with the mission, goals and policies of the Department, and Case Management Agency and ensure that:

    a. Informed Consent is obtained when required from the person receiving services, the Parent of a minor, or the Guardian or other Legally Authorized Representative as appropriate;

    b. Modifications of the rights of members occurs only within procedural safeguards as stipulated in Section 8.7001 and that continued modification of such rights is reviewed by the individual, their Guardian or other Legally Authorized Representative, and the rest of the Member Identified Team at a frequency decided by the team, but not less than every six months;

    c. Psychotropic medications and other prescribed medications used for the purpose of modifying the behavior of Members receiving services through the Intellectual and Developmental Disability waivers are used in accordance with the requirements of Section 8.7416, and are monitored by the Human Rights Committee on a regular basis; and,

    d. Allegations of mistreatment, abuse, neglect and exploitation are investigated, and the investigation report is reviewed.

10. RESEARCH

    a. Any experimental research performed by or under the supervision of the Case Management Agency, the Community Centered Board, service agency or Regional Center shall be governed by policies/procedures which shall:

        i. Require adherence to ethical and design standards in the conduct of research;

        ii. Require review by the Human Rights Committee;

        iii. Address the adequacy of the research design;

iv. Address the qualifications of the individuals responsible for coordinating the project;

v. Address the benefits of the research in general;

vi. Address the benefits and risks to the participants;

vii. Address the benefits to the agency;

viii. Address the possible disruptive effects of the project on agency operations;

ix. Require obtaining informed consent from participants, their guardians or the parents of a minor. Such consent may be given only after consultation with:

a. The member selected team; and,

b. A developmental disabilities professional not affiliated with the service agency from which the person receives services; and

x. Require procedures for dealing with any potentially harmful effects that may occur in the course of the research activities.

b. No person shall be subjected to experimental research or hazardous treatment procedures if the person implicitly or expressly objects to such procedures or such procedures are prohibited.

8.7202.R Denials/Discontinuations/Adverse Actions

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

a. Financial Eligibility

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

ii. If the individual or Member is found to be financially ineligible for HCBS or Long-Term Services and Supports benefits, the Case

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

b. Functional Eligibility and Target Group

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

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

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

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

c. Receipt of Services

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

1) The individual has not received an HCBS Waiver service for one calendar month,;

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

d. Institutional Status

i. The Case Management Agency shall notify the individual of denial or discontinuation by sending the Long-Term Care Waiver Program Notice of Action when the Case Manager determines that the individual does not meet the following program eligibility requirements.

1) The individual is not eligible to receive HCBS services while a resident of a nursing facility, hospital, or other Institution; or

2) The individual who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.

2. The Long-Term Care Waiver Program Notice of Action shall be completed in the Information Management System for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, and at the time of discontinuation.

3. In the event the individual appeals a denial or discontinuation action, except for reasons related to Financial Eligibility, the Case Manager shall attend the appeal hearing to defend the denial or discontinuation action.

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

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

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

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

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

   e. The individual or Applicant voluntarily withdraws.

5. The Case Management Agency shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the Case Management Agency has made a denial or adverse action against an individual.

6. The Case Management Agency shall notify the providers in the individual's service plan within one (1) business day of the discontinuation or adverse action.

7. The Case Manager shall notify all providers on the Person-Centered Support Plan no later than within one (1) business day of discontinuation or adverse action.

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

9. 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 affects Medicaid Financial Eligibility.

10. The Case Management Agency shall notify the county eligibility enrollment specialist of the appropriate county department of social services:

    a. At the same time it notifies the individual seeking or receiving services of the adverse action;

    b. When the individual has filed a written appeal with the Case Management Agency; and

    c. When the individual has withdrawn the appeal or a final Agency decision has been entered.

11. The Applicant or individual shall be informed of an adverse action if the individual or Applicant is determined ineligible and the following:

    a. The individual or Applicant is detained or resides in a correctional facility, or

    b. The individual or Applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

12. The Case Management Agency shall refer individuals to the Medicaid Buy-In program who do not qualify for waivers due to Financial Eligibility.

13. Case Management Agencies shall document in the Information Management System all voluntary withdrawals from all programs.

8.7202.S Case Management Support to Members and Families Receiving Services Related to Dispute Resolution with Provider Agencies

1. Every Case Management Agency shall have procedures which comply with requirements as set forth in these rules and Section 25.5-10- 212, C.R.S., for resolution of disputes between Members or individuals and Provider Agencies involving individuals or Members. This dispute resolution does not supersede or negate the requirement for a Long Term Care Waiver Program Notice of Action (LTC-803). Case Management Agency dispute resolution procedures shall include but not limited to the following circumstances:

    a. The individual or Member is no longer eligible for services or supports;

    b. Services or supports are to be terminated; or,

    c. Services set forth in the Person-Centered Support Plan are to be changed or reduced, or denied.

2. The procedure shall contain an explanation of the process to be used by Members or Applicants for services or Parents of a minor, Guardians and/or other Legally Authorized Representatives in the event that they are dissatisfied with the decision or action of the regional center or Provider Agency.

3. The dispute resolution procedure shall be stated in writing, in English. Interpretation in native languages other than English and through such modes of communication as may be necessary for the Member's accommodation needs shall be made available upon request.

    a. The procedure shall be provided, orally and in writing, to all Members or Applicants for services and Parents of a minor, Guardian, and/or other Legally Authorized Representative at the time of application, at the time the individualized plan is developed, any time changes in the plan are contemplated, and upon request by the above named persons.

    b. The procedure shall state that use of the dispute resolution procedure shall not prejudice the future provision of appropriate services or supports to the individual in need of and/or receiving services.

    c. The procedure shall state that an individual shall not be coerced, intimidated, threatened or retaliated against because that individual has exercised his or her right to file a Complaint or has participated in the dispute resolution process.

4. The procedure of the Case Management Agency shall stipulate that notice of action proposed as defined in Section 8.7202.R shall be provided to the Member/Applicant, and to the person's Parents if a minor, Guardian and/or other Legally Authorized Representative at least fifteen (15) days prior to the date actions enumerated in Section 8.7202.S.1 become effective. The above named persons may dispute such action(s) by filing a Complaint with the Agency initiating the action. Upon such Complaint, the procedures set forth by the Case Management Agency shall be initiated.

5. The procedure of the Case Management Agency shall provide the opportunity for resolution of any dispute through an informal negotiation process which may be waived only by mutual consent. Mediation by the Case Manager could be considered as one means to informal negotiation if both parties voluntarily agree to this process.

6. The opportunity for resolution of a dispute through informal negotiation shall include the scheduling of a meeting of all parties or their representatives within fifteen (15) days of the receipt of the Complaint.

7. After opportunities for informal negotiation of the dispute have been attempted or mutually waived, either party may request that the dispute resolution process set forth by the Case Management Agency and the following provisions shall be initiated. Parent(s) or Guardian of a minor, age birth to three years, may utilize

the dispute resolution process specified under the requirements of the Procedural Safe Guards for early intervention services pursuant to the Individuals with Disabilities Education Act.

8. The dispute resolution procedures of the Case Management Agency shall, at a minimum, afford due process by providing for:

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

    b. Timely notification of the meeting (at least ten days prior) to all parties unless waived by the objecting parties;

    c. Representation by counsel, Legally Authorized Representative, or another individual if the objecting party desires;

    d. The opportunity to respond to or question the opposing position;

    e. Recording of the proceeding by electronic device or reporter;

    f. Issuance of a written decision setting forth the reasons therefore within fifteen (15) days of the meeting;

    g. Notification that if the dispute is not resolved, the objecting party may request that the Executive Director of the Department or their designee review the decision; and,

    h. Notification to the Department by the Case Management Agency of all disputes proceeding and the decision issued.

9. The dispute resolution procedure of the Department shall be as follows:

    a. A request to the Executive Director of the Department to review the outcome of the dispute resolution process shall be submitted to the Department within fifteen (15) working days from which the written decision was postmarked;

    b. The request for review shall also contain a statement of the matters in dispute and all information or evidence which is deemed relevant to a thorough review of the matter. The Case Management Agency shall be afforded the opportunity to respond within fifteen (15) working days;

    c. The Executive Director of the Department or designee shall have the right to additional information and may request oral argument or a hearing if

deemed necessary by the Executive Director or designee to render a decision;

d. The Executive Director of the Department or designee shall be de novo and a decision shall be rendered within ten (10) working days of the submission of all relevant information; and,

e. The decision of the Executive Director of the Department shall constitute Final Agency Action regarding dispute.

10. No Member may be terminated from services or supports during the dispute resolution process unless the Department determines an emergency situation, as meeting the criteria set forth in Section 8.7000.A.4 exists.

8.7202.T Disputes between Department and Case Management Agency

1. The following shall apply in the event that the terms of the Case Management Agency requirements and responsibilities in these rules for Targeted Case Management Activities are disputed by either party:

a. The Case Management Agency shall notify the Director of the Office of Community Living of the circumstances of the dispute.

b. The parties shall informally meet at a mutually agreeable time to attempt resolution.

c. If the dispute cannot be resolved through this informal process, then the formal process at Section 8.7202 shall be used.

d. The Case Management Agency shall submit a written request for formal dispute resolution to the Department.

i. The request shall state the specific grounds for the dispute.

ii. It shall include all available exhibits, evidence, arguments, and documents believed to substantiate the protest, and the relief requested.

e. The Department may request additional information deemed necessary to resolve the dispute.

f. Within fifteen (15) working days following the receipt of written materials and additional requested information, the Department shall respond to the request by issuing a written decision, which shall be inclusive of the reasons for the decision.

g. A copy of the documentation presented or considered, the decision made and the contract shall be maintained in the Department’s files.

h. The Department's decision shall represent final Agency action on the disputed issue.

i. Notwithstanding the dispute, the Case Management Agency shall honor all contractual obligations entered into in its contract with the Department. No Agency shall have its contract terminated pending resolution of a contractual dispute, unless an emergency order is necessary for the preservation of public health, safety or welfare, as determined pursuant to Section 8.7000.A.4.

j. Nothing in this procedure shall prohibit the Department from initiating corrective action based on evidence presented in the request for Departmental intervention or during its review.

k. Disputes related to administrative Case Management Activities must follow the process outlined in the Case Management Agency contract.

8.7202.U Continuous Quality Improvement of the Case Management Agency

1. To ensure the Case Management Agency is completing Case Management Activities according to requirements, the Department shall conduct performance reviews and evaluations of the Case Management Agency.

2. The Department may work with the Case Management Agency in the completion of any performance reviews and evaluations, and/or the Department may complete any or all performance reviews and evaluations independently, at the Department’s sole discretion.

3. The Case Management Agency shall provide all information necessary, as determined by the Department for the Department to complete performance reviews and evaluations, upon the Department’s request.

4. The Case Management Agency shall perform internal oversight of their Agency work product to ensure Case Management Activities described in rule and contract are performed as required.

5. The Department shall make the results of any performance reviews and evaluations available to the public and publicly post the results of any performance reviews and evaluations.

6. The Department may recoup funding as a result of any performance review and evaluation where payment was rendered for services not complete and/or not in alignment with federal and/or state regulations or Contract.

7. A Case Management Agency may be placed on corrective action requiring remediation based on the result of any performance review or evaluation.

8. Case Management Agencies shall allow access by authorized personnel of the Department, and/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.

9. Case Management Agency Satisfaction Survey

    a. At least annually, the Case Management Agency shall survey a random sample of Members to determine their level of satisfaction with services provided by the Agency. The Case Management Agency shall have a written policy and procedure for completing the Member satisfaction survey.

    b. The random sample of individuals shall constitute forty (40) individuals or ten percent (10%) of the Case Management Agency's average monthly caseload, whichever is higher.

    c. The individual satisfaction survey shall conform to guidelines provided by the Department, including multiple survey formats and shall be ADA compliant.

    d. The results of the individual satisfaction survey shall be made available to the Department upon request and shall be utilized for the Case Management Agency's quality assurance and resource development efforts.

    e. The Case Management Agency shall assure that consumer information regarding HCBS waiver programs is available for all individuals at the local level.

    f. The Survey results shall be provided to the Community Advisory Committee for review regarding actions necessary to respond to quality concerns or issues and community engagement.

8.7202.V Provision of State Program Services

1. The Case Management Agency is responsible for the administration of state plan Long-Term Services and Supports programs including: State Supported Living Services (State-SLS), OBRA-SS, and Family Support Services Program (FSSP), in accordance with Medical Services Board regulations, and the Case Management Agency contract, and all the requirements associated with these programs including, but not limited to: Family Support Council development and maintenance, rates for State SLS and monitoring of services, and the PASSR program.

2. Family Support Program

a. Case Management for State General Fund program support is the coordination of services provided for individuals with an Intellectual and Developmental Disability or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education, and other services to ensure nonduplication of services, and monitoring to ensure the effective and efficient provision of services across multiple funding sources.

b. At minimum, the Case Manager is responsible for:

i. Determining initial and ongoing eligibility for the FSSP;

ii. Assisting Applicants with the Assessment;

iii. The development and annual Reassessment of the Family Support Plan (FSP); and

iv. Ensuring service delivery in accordance with the FSP, and

v. Coordinating with the Family Support Council as needed

3. OBRA-SS State General Fund Program

a. Case Management Agencies shall follow all contractual obligations, rules and regulations pertaining to OBRA-SS at 42 CFR 483.

4. State Supported Living Services State General Fund Program

a. The Case Manager shall coordinate, authorize, and monitor services based on the approved State-SLS Person-Centered Support Plan.

b. The Case Manager shall complete monitoring activities in compliance with 8.7557.D.4.

c. The Case Management Agency Case Manager shall assist individuals to gain access to other resources for which they are eligible and to ensure individuals secure long-term support as efficiently as possible.

d. The Case Management Agency Case Manager shall provide all State-SLS documentation upon the request from the Department.

e. Referrals to the State-SLS program shall be made through the Case Management Agency in the defined service area the individual resides in.

5. Home Care Allowance program

a. Case Management Agencies shall contract with the Colorado Department of Human Services to administer the Home Care Allowance program.

b. The Case Managers shall complete all requirements for Home Care Allowance in accordance with 9 C.C.R. 2503-5; and with any applicable contract(s).

8.7202.W Organized Health Care Delivery System (OHCDS)

1. The Organized Health Care Delivery System for waivers is the Case Management Agency as designated by the Department in accordance with Section 25.5 -10-209, C.R.S.

2. The Organized Health Care Delivery System is the Medicaid provider of record for a Member whose services are delivered through the Organized Health Care Delivery System.

3. The Organized Health Care Delivery System shall maintain a Medicaid provider agreement with the Department to deliver Waiver Services according to the current federally approved waiver.

4. The Organized Health Care Delivery System may contract and/or employ for delivery of approved Waiver Services for the Organized Health Care Delivery System.

5. The Organized Health Care Delivery System shall:

   a. Ensure that the Contractor and/or employee meets minimum provider qualifications as set forth in the applicable HCBS waiver;

   b. Ensure that services are delivered according to the applicable HCBS waiver definitions and as identified in the Member's Service Plan;

   c. Ensure that any subcontractor maintains sufficient documentation to support the claims submitted; and

   d. Monitor the health and safety of HCBS waiver Members receiving services from a subcontractor and report concerns for health and welfare to the proper authorities.

6. The Organized Health Care Delivery System is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The Organized Health Care Delivery System shall:

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

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

c. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to individuals or Members;

d. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and the Department's procedures:

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

d. Collect and maintain the data used to develop provider rates and ensure data includes the costs for allowable services provided to Members to address the individual and stakeholders' needs, that are allowable activities within the HCBS waiver service definition and that supports the established rate;

e. Maintain documentation of provider reimbursement rates and provide the documentation to the Department, and Centers for Medicare and Medicaid Services (CMS); and

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

8.7202.X Member and Individual Documentation and Recordkeeping

1. Documentation includes:

a. Documentation of the Member's choice of services, providers, nursing home placement, or other services, including a signed statement of choice from the Member;

b. Documentation that the individual or Member was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the individual understands his/her right to change providers;

c. Except when a individual or Member is residing in an alternative care facility, documentation to include a process, developed in coordination with the Member, the Member's Family or Guardian and the Member's physician, by which the Member may receive necessary care if the Member's Family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The individual and the individual's Family or Guardian shall be duly informed of these alternative care provisions at the time the service plan is initiated.

2. Case Managers shall support Members in determining their per diem payment obligation pursuant to Section 8.509.31.E. Case Managers shall inform Members residing in an Alternative Care Facility of their individual 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 diem payment amount.

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

    b. Copies of individual payment forms shall be kept in the individual files at the Case Management Agency and shall not be mailed to the State of its agent except as required for a Prior Authorization Request, pursuant to Section 8.509.31(G)], or if requested by the state for monitoring purposes.

3. All Case Management documentation shall meet all of the following standards:

    a. Records shall be objective and understandable;

    b. Records shall be prepared at the time of the activity or no later than five (5) business days from the time of the activity;

    c. Records shall be dated according to the date of the activity, including the year;

    d. Records shall be entered into the Department's Information Management System;

    e. Records shall 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 judgment or conclusion;

    i. All persons and agencies referenced in the documentation must be identified by name and by relationship to the Member;

    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.

4. Documentation of Contacts and Case Management Activities in the Department Prescribed Information Management System.

5. All case documentation must be entered into the Department's Information Management System within five (5) business days from the date of activity.

6. The Case Manager shall use the Department-prescribed Information Management System for purposes of documentation of all Case Management Activities, monitoring of service delivery, and service effectiveness. If applicable, the individual's Legally Authorized Representative or Long-Term Services and Supports Representative or both shall be identified in the case record, with a copy of appropriate documentation.

7. The Case Management Agency may accept physical or digital signatures on Department forms. If the individual is unable to sign a form requiring his/her signature because of a medical condition, any mark the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a Guardian or other Legally Authorized Representative shall be accepted.

8.7202.Y Communication

1. The Case Management Agency's Case Manager shall be responsible for ensuring materials, documents, and information used to conduct Case Management Activities are adapted to the cultural background, language, ethnic origin and preferred means of communication of the individual.

2. In addition to any communication requirements specified elsewhere in these rules, the Case Manager shall be responsible for the following communications:

   a. The Case Manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of a Member in Case Management Agency-served programs, including changes in income, within one (1) working day after the Case Manager learns of the change. The Case Manager shall provide the eligibility enrollment specialist with copies of the certification page of the approved Level of Care Screen form.

   b. If the individual has an open adult protective services (APS) or child protective services (CPS) case at the county department of social services, the Case Manager shall keep the individual's APS or CPS worker informed of the individual's status and shall participate in mutual staffing of the individual's case.

c. The Case Manager shall report to the Colorado Department of Public Health and Environment (CDPHE) any Congregate Facility which is not licensed.

d. The Case Manager shall inform all Alternative Care Facility individuals of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

e. Within five working days of receipt of the approved Prior Authorization Request (PAR) form, from the fiscal agent, the Case Manager shall provide copies to all the HCBS providers in the Person-Centered Support Plan.

f. The Case Manager shall coordinate with the Regional Accountable Entity and Behavioral Health Administration along with other community partners involved with the Members' services and supports.

g. The Case Manager shall notify the Utilization Review Contractor (URC), on a form prescribed by the Department, within 30 calendar days, of the outcome when a Member is not Diverted.

h. Case Managers shall maintain communication with Members, Family Members, providers and other necessary parties within minimum standards for returned communication as described in contract.

8.7202.Z Targeted Case Management Activity Billing and Payment Liability

1. Billing:

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

i. The name of the individual;

ii. The date of the activity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Exclusions

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

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

ii. Persons residing in a Class I nursing facility.

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

3. Payment Liability

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

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

8.7202.AA Support Levels and Algorithms

1. Definitions

a) Algorithm means a formula that establishes a set of rules that precisely defines a sequence of operations. An Algorithm is used to assign Members into one of six Support Levels in the Home and Community Based Services-Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.

b) Respondent means a person participating in the Support Level Assessment who has knowledge of the Member's skills and abilities in various areas of their lives. The Member may be their own Respondent by

themselves or with support for the Support Level Assessment. For Respondents who are not the Member, they must have recently observed the Member directly in one or more places such as home, work, or in the community.

c) Interviewer means an individual formally trained in the administration and implementation of the Support Level Assessment by a Department approved trainer using the Department approved curriculum.

d) Support Level means a numeric value determined using an Algorithm that places Members into groups with other Members who have similar overall support needs.

e) Virtual Meeting Platform means a form of communication that enables individuals in different physical locations to use their mobile or internet connected devices to meet in the same virtual room.

1) Support Level Assessments

a) Since 2007, the Supports Intensity Scale (SIS-A) Assessment was required for enrollment into the HCBS-DD and HCBS-SLS waivers and used to determine a Member's Support Level.

i) The Department will discontinue use of the Supports Intensity Scale (SIS-A) Assessment to determine Support Levels for initial enrollments into the HCBS-DD and HCBS-SLS waivers after June 30, 2025.

ii) Supports Intensity Scale (SIS-A) Assessment Support Levels will continue to be utilized for those Members who have them assigned prior to July 1, 2025.

b) Effective July 1, 2025, the Interim Support Level Assessment (ISLA) will replace the Supports Intensity Scale (SIS-A) Assessment used for initial HCBS-DD and HCBS-SLS enrollments to determine the Member's Support Level.

i) The Interim Support Level Assessment (ISLA) will be used until the Department fully implements the Colorado Single Assessment (CSA) and Person-Centered Budget Algorithm (PCBA) for Resource Allocation across all HCBS waivers.

c) SIS-A and ISLA Support Levels will be used simultaneously after July 1, 2025; however, a single Member shall never have both a SIS-A and ISLA Support Level simultaneously.

d) The Case Management Agency shall conduct a Support Level Assessment for a Member at the time of initial enrollment into HCBS-DD and HCBS-SLS.

i) Interviewers conducting Support Level Assessments shall be trained and qualified to perform the assessments.

ii) The Interviewer conducting the Support Level Assessment shall not also act as a Respondent for the same assessment.

iii) The Case Management Agency shall:

(1) Notify the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, of the requirement for and the right to participate in the Support Level Assessment.

(2) Support and encourage the Member to participate in the Support Level Assessment.

(a) If the Member chooses not to participate in the Support Level Assessment, the Case Management Agency shall document their choice in the Member's record on the Department prescribed Information Management System; and,

(b) Assist the Member or other Member Identified Team members to identify who will participate on their behalf (family, friends, unpaid support, etc.) and document their choice in the Department prescribed Information Management System.

(3) Assist the Member to identify other Respondents (Legal Guardian, family, friends, unpaid support, etc.) whom they choose to participate in the Support Level Assessment.

(4) Allow the Member to complete the Support Level Assessment as the only Respondent if they choose.

(5) Document the Member's selection of Respondents or choice to be the only Respondent in the Department prescribed Information Management System.

(6) Follow person-centered practices by accommodating the Member's preference in completing the Support Level Assessment via in-person, in the Member's home, at an alternate location, or by virtual meeting platform.

(7) Inform the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, of the purpose of the Support Level Assessment, the Complaint Process, and the Support Level Review Process.

(8) Provide a copy of the completed Support Level Assessment to the Member within 30 calendar days of the assessment.

(a) The Case Management Agency shall document provision of a copy of the Support Level Assessment to the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, in the Department prescribed Information Management System.

2) Support Levels

a) A Support Level reflects the assessed support needs of a Member and is required for a Member enrolled in the Home and Community-Based Services-Developmental Disabilities (HCBS-DD) or the Home and Community-Based Services-Supported Living Services (HCBS-SLS) waiver.

b) The Support Level is used as a factor for Day Habilitation, Supported Employment, and Residential Habilitation services to determine the rate paid to Providers.

c) A Member shall be assigned into one of six Support Levels according to their overall support needs and based upon the standardized Algorithm for HCBS-DD or HCBS-SLS.

i) The Supports Intensity Scale (SIS-A) Assessment converts subscale raw scores for each section into standard scores for each section, which are used in the Algorithm for Supports Intensity Scale (SIS-A) Assessment Support Levels.

ii) Supports Intensity Scale (SIS-A) Assessment Algorithm factors:

(a) Standard scores from Section 2: Parts A (Home Living Activities), B (Community Living Activities), and E (Health and Safety Activities) (ABE) from the SIS-A,

(b) Total scores from Section 1A: Exceptional Medial Support Needs score from the SIS-A,

(c) Total scores from Section 1B: Exceptional Behavioral Support Needs score from the SIS-A, and

(d) Whether the Member presents as a safety risk, defined in Section 8.7100.A Definitions, as follows:

(i) In HCBS-DD, Extreme Safety Risk to Others or Extreme Safety Risk to Self.

(ii) In HCBS-SLS, Extreme Safety Risk to Others.

iii) Supports Intensity Scale (SIS-A) Assessment Algorithm Formula Table

SIS-A Support Level/Subgroup
SIS-A Support Level 1
Subgroup 1A: ∑ 2ABE ≤ 25; 1A ≤ 1 AND 1B ≤ 2
Subgroup 1B: ∑ 2ABE ≤ 25; 1A ≤ 2 AND 1B 3-5
Subgroup 1C: ∑ 2ABE ≤ 25; 1A 3-4 AND 1B 3-5
SIS-A Support Level 2
Subgroup 2A: ∑ 2ABE 26-30; 1A ≤ 1 AND 1B ≤ 2
Subgroup 2B: ∑ 2ABE 26-30; 1A ≤ 2 AND 1B 3-5
Subgroup 2C: ∑ 2ABE 26-30; 1A 3-4 AND 1B 3-5
Subgroup 1D: ∑ 2ABE ≤ 25; 1A 5-6
Subgroup 1G: ∑ 2ABE ≤ 25; 1B 6-9
Subgroup 2D: ∑ 2ABE 26-30; 1A 5-6
Subgroup 2G: ∑ 2ABE 26-30; 1B 6-9
Subgroup 3A: ∑ 2ABE 31-33; 1A ≤ 1 AND 1B ≤ 2
Subgroup 3B: ∑ 2ABE 31-33 1A ≤ 2 AND 1B 3-5
SIS-A Support Level 3
Subgroup 1H: ∑ 2ABE ≤ 25; 1B 10-13
Subgroup 2H: ∑ 2ABE 26-30; 1B 10-13
Subgroup 3C: ∑ 2ABE 31-33; 1A 3-4 AND 1B 3-5
Subgroup 3D: ∑ 2ABE 31-33; 1A 3-6
Subgroup 3G: ∑ 2ABE 31-33; 1B 6-9
Subgroup 4A: ∑ 2ABE ≥ 34; 1A ≤ 1 AND 1B ≤ 2
Subgroup 4B: ∑ 2ABE ≥ 34 1A ≤ 2 AND 1B 3-5
SIS-A Support Level 4
Subgroup 1E: ∑ 2ABE ≤ 25; 1A 7-8

SIS-A Support Level/Subgroup
Subgroup 1F: ∑ 2ABE ≤ 25; 1A ≥ 9
Subgroup 1I: ∑ 2ABE ≤ 25; 1B 14-15
Subgroup 1J: ∑ 2ABE ≤ 25; 1B ≥ 16
Subgroup 2E: ∑ 2ABE 26-30; 1A 7-8
Subgroup 2I: ∑ 2ABE 26-30; 1B 14-15
Subgroup 2J: ∑ 2ABE 26-30; 1B ≥ 16
Subgroup 3E: ∑ 2ABE 31-33; 1A 7-8
Subgroup 3H: ∑ 2ABE 31-33; 1B 10-13
Subgroup 4C: ∑ 2ABE ≥ 34; 1A 3-4 AND 1B 3-5
Subgroup 4G: ∑ 2ABE ≥ 34; 1B 6-9
SIS-A Support Level 5
Subgroup 2F: ∑ 2ABE 26-30; 1A ≥ 9
Subgroup 3I: ∑ 2ABE 31-33; 1B 14-15
Subgroup 3J: ∑ 2ABE 31-33; 1B ≥ 16
Subgroup 4D: ∑ 2ABE ≥ 34; 1A 3-6
Subgroup 4E: ∑ 2ABE ≥ 34; 1A 7-8
Subgroup 4H: ∑ 2ABE ≥ 34; 1B 10-13
Subgroup 4I: ∑ 2ABE ≥ 34; 1B 14-15
Group 5A: Extreme Safety Risk to Others AND 1b ≤ 11
SIS-A Support Level 6
Subgroup 4J: ∑ 2ABE ≥ 34; 1B ≥ 16
Subgroup 3F: ∑ 2ABE 31-33; 1A ≥ 9
Subgroup 4F: ∑ 2ABE ≥ 34; 1A ≥ 9
Group 6A: Extreme Safety Risk to Self AND Extreme Safety Risk to Others AND 1b ≥ 12
Group 6B: Extreme Safety Risk to Others AND 1b ≥ 12
Extreme Safety Risk to Self – this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 3, level 2 increases to level 4, level 3 increases to level 4, level 4 increases to level 5. Subgroup 6A outlines the conditions in which level 5 may increase to level 6.
Extreme Safety Risk to Others – this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 5, level 2 increases to level 5, level 3 increases to level 5, and level 4 increases to level 6. Subgroup 6B outlines the conditions in which level 5 may increase to level 6.

iv) The Interim Support Level Assessment (ISLA) converts subscale raw scores for into scale scores for each section, which are used in the Algorithm for Interim Support Level Assessment (ISLA) Support Levels.

v) Interim Support Level Assessment (ISLA) Algorithm factors:

(1) Functioning (ADLs and IADLs), and

(2) Health (Medical), and,

(3) Psychosocial (Behavior and Mental Health), and,

(4) Memory and Cognitive, and,

(5) Social Environment and Safety; and,

(6) Whether the Member presents as a safety risk, defined in Section 8.7100.A Definitions, as follows:

(a) In the HCBS-SLS waiver, Extreme Safety Risk to Others.

(b) In the HCBS-DD waiver, Extreme Safety Risk to Others or Extreme Safety Risk to Self.

vi) Interim Support Level Assessment (ISLA) Algorithm Formula Table is posted on the Department's website and can be found at (link).

vii) The results of the Algorithm are used to assign Members to Support Levels one through six; with a Support Level one indicating a minimal need for supports and a Support Level six indicating a significantly higher need for supports.

(1) In HCBS-DD, the Department may assign a Support Level seven (7) reimbursement rate for Residential Habilitation and/or Day Habilitation services provided to a Member with extraordinary overall needs.

(2) These Support Level seven (7) requests must be initiated by the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, and submitted by the Case Management Agency to the Department for review.

viii) For HCBS-SLS, the Support Level will determine the Service Plan Authorization Limit (SPAL), defined at Section 8.7200.B, and the rate of reimbursement for Day Habilitation and Supported Employment Service.

(1) The HCBS-SLS SPAL will remain in place for already established Support Plan certifications that end after July 1, 2025.

(a) The HCBS-SLS SPAL shall not apply to Support Plan Continued Stay Reviews held after July 1, 2025.

(2) For Members newly enrolling in HCBS-SLS and Community First Choice (CFC) on or after July 1, 2025, the SPAL shall not apply.

(3) The SPAL is posted on the Department's webpage.

ix) For HCBS-DD, Support Level determines the rate of reimbursement for Supported Employment Services, Day Habilitation, and Residential Habilitation Services.

x) Specific scores from the Member's Support Level Assessment shall be used in addition to Risk Factor scores to calculate the Member's Support Level in HCBS-DD and HCBS-SLS.

(1) The Case Management Agency in consultation with the Member Identified Team shall make a determination whether a Member meets the definition of Extreme Safety Risk to Others or Extreme Safety Risk to Self through the following process:

(a) The Case Manager shall:

(i) Document the Member Identified Team discussion of the Rights Modification identifying the line of-sight supervision and/or secured, controlled setting justification, in the Member's record on the Department prescribed Information Management System; and,

(ii) Follow the Rights Modification process outlined in Section 8.7001.B.4.

(b) The Case Manager Supervisor shall:

(i) Verify the Member meets safety risk criteria,

(ii) Verify the signed Informed Consent for the Rights Modification is in the Member's record on the Department prescribed Information Management System; and,

(iii) Document that the Member meets the Extreme Safety Risk to Others or Extreme Safety Risk to Self definition(s) in the Department prescribed Information Management System.

(iv) The Case Management Agency shall review the status of the Member's Safety Risk Factors at least annually or when significant changes occur, to ensure that the Member continues to meet the definition(s).

(c) At the point a Member no longer meets the definition(s) of Extreme Safety Risk to Others or Extreme Safety Risk to Self, their status must be changed in the Department prescribed Information Management System which will auto-calculate to the Member's current Algorithm Support Level and the Member's Person-Centered Support Plan shall be updated to reflect the removal of the Risk Factor and any changes in related, identified support needs within 10 business days of the definition(s) no longer being met or, in cases where Section 8.7202.AA.C(xiii)(4)(b)(i-iii), applies, within 10 business days of receipt of approval or denial of the Support Level Review request.

(d) For cases in which a Member's behavior does not satisfy a Safety Risk Factor definition but the Member's needs continue to be substantially higher than those typical of their assigned Support Level (without adjustments for risk factors) and a Rights Modification continues to be in place, the Member Identified Team may consider a Support Level Review request, as outlined in Section 8.7202.5, as a part of the person-centered support planning and Rights Modification processes.

(i) If the Member Identified Team determines a Support Level Review request is needed, the Case Management Agency shall submit a Support Level Review request with input from the Member Identified Team which includes, but is not limited to, detailed information from the Person-Centered Support Plan describing the extensive supports needed and the Rights Modification(s), to include all requirements outlined in Section 8.7001.B.

(ii) The Department shall review the Support Level Review request as outlined in Section 8.7202.5.

(iii) Rights shall be restored as soon as circumstances justify.

1. When rights are restored prior to the end date of the Support Level Review approval period, the Case Management Agency shall notify the Department of the change in support needs in a manner determined by the Department.

2. When rights are restored, the Department shall adjust the Support Level override in the Department prescribed Information Management System to the original assessed Algorithm Support Level.

3. The Case Management Agency shall make any necessary Person-Centered Support Plan and Prior Authorization (PAR) revisions resulting from the Support Level changes within 10 business days of the affected Support Level change.

d) The Case Management Agency shall inform each Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, of their Support Level at the time of the initial or Continued Stay Review (CSR) Person-Centered Support Plan meeting or when the Support Level changes for any reason.

i) Notification to the Member of a Support Level change shall occur within 20 business days of the date of the Support Level change.

ii) Pursuant to the Department's rules in Section 8.057.2.A, Section 8.7202.R, and Section 8.7202.S.1(c), the Member shall be notified when a waiver service is changed, reduced, or denied. At any time, the Member may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3.A.

3) Support Level Assessment Complaint Process

a) The Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, may file a complaint regarding the

administration of the Support Level Assessment up to 30 calendar days after the Member's receipt of the Support Level Assessment document.

b) The complaint shall be filed verbally or in writing with the Member's Case Management Agency. Additional information to support the complaint may be submitted at that time. If the complaint has been filed verbally the Case Management Agency shall document in the Member's record on the Department-prescribed Information Management System the time, date and details surrounding the complaint.

c) The Case Management Agency shall make efforts to resolve the complaint and provide the complainant with a written response within 10 business days after receipt of the complaint.

d) When a resolution cannot be reached, the Case Management Agency shall inform the complainant that they may submit the complaint to the Department through the Department's Complaint Form within 30 calendar days after receipt of the Case Management Agency response.

e) The Department shall provide a written response to the complainant within 15 business days after receipt of the complaint.

4) Support Level Review Process

a) The Case Management Agency shall request a review of the Support Level assigned on behalf of the Member, their Legal Guardian, or their Legally Authorized Representative when they have reason to believe it does not meet the Member's needs.

b) When a Support Level Review is requested, the Case Management Agency shall complete the request with input from the Member Identified Team in a manner determined by the Department on the Department's prescribed request form.

c) Support Level Review requests must be initiated by the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, and submitted by the Case Management Agency to the Department for review.

d) Once the request form is completed, the Case Management Agency shall provide an opportunity for the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, to review the request and provide additional information prior to submission to the Department for review.

e) The Case Management Agency shall submit the Support Level Review request form to the Department within 30 calendar days of the receipt of all necessary information.

f) The Department shall convene a review panel to examine Support Level Review requests monthly or as needed.

i) The review panel shall be comprised of the following:

(1) A minimum of three members designated by the Department.

(2) Members shall include staff from the Department with extensive knowledge and experience with the assessments used to determine Support Levels, Case Management, and HCBS waiver services.

ii) The review panel:

(1) Shall examine all of the information submitted by the Case Management Agency and identify any significant factors not included in the Support Level calculation, which may cause the Member to have substantially higher support needs than those in the established Support Level.

(2) In cases where the panel finds that the Member does have substantially higher support needs than those in the established Support Level, the panel may assign the Member to a Support Level that is a closer representation of the Member's overall support needs.

(a) A Member who has been assigned to a higher Support Level shall have this assignment re-examined by the review panel at a frequency determined by the Department.

(i) The Case Management Agency shall submit a Support Level Review request to have the Member’s Support Level re-examined no later than 30 calendar days prior to the end date determined by the Department of the increased Support Level.

(ii) The panel may determine that the Member's condition necessitating a higher Support Level is unlikely to improve and, therefore, does not require a re-examination and, therefore, does not have an end date.

g) The Department shall provide the Case Management Agency with the written decision regarding the requested review of the Member's Support Level within 15 business days after the panel meeting. The written

decision notification shall include the date of the Support Level Review request, the Support Level determination, the effective date, and the end date of the increased Support Level and, if denied, the reason for denial of an increased Support Level.

h) The Case Management Agency shall provide the written decision to the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable.

i) The results of the panel review for a Member enrolled in HCBS-DD are conclusive.

ii) If a Member enrolled in HCBS-SLS, their Legal Guardian, or their Legally Authorized Representative, if applicable, disagrees with the decision provided by the panel, the Member, their Legal Guardian, or their Legally Authorized Representative may request a review by the Department's Executive Director or their designee, within 15 business days after the receipt of the decision.

(1) The Department's Executive Director, or their designee, shall review the request and provide a written decision within 15 business days of receipt of the requested review.

(2) The decision of the Department's Executive Director, or their designee, shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.

i) The Case Management Agency shall make any necessary Person-Centered Support Plan and Prior Authorization Request (PAR) revisions resulting from the Support Level changes within 10 business days of receipt of approval or denial of the Support Level Review request.

j) The Member shall be notified, pursuant to the Department's rules in Section 8.057.2.A, Section 8.7202.R, and Section 8.7202.S.1(c) when a waiver service is changed, reduced, or denied. At any time, the Member may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3.A.

5) Annual Support Level Assessment Overview

a) The Case Manager shall provide an overview of the results of the most recent Support Level Assessment during the Continued Stay Review (CSR) Person-Centered Support Plan (PSCP) meeting.

b) For SIS-A, this overview shall include discussion of:

i) The Exceptional Medical and/or Behavioral Support Needs identified in Section 1 of the SIS-A,

ii) The areas of priority support needs identified in Section 2 of the SIS-A,

iii) The resulting Support Level, and

iv) The services necessary to meet these priority areas.

c) For ISLA, the overview shall include discussion of:

i) The Exceptional Medical/Health and/or Psychosocial Support Needs identified in the ISLA,

ii) The areas of priority support needs identified in the Activities of Daily Living and Instrumental Activities of Daily Living scale,

iii) The resulting Support Level, and

iv) The services necessary to meet these priority areas.

d) If upon review of the results of the Support Level Assessment there is a significant change in the Member's condition or circumstances, the Case Manager should refer to Section 8.7202.AA.5 Support Level Review Process.

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

1. Post Eligibility Treatment of Income Application

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

b. Post Eligibility Treatment of Income Application is required for Medicaid Members enrolled in the HCBS Elderly, Blind, and Disabled (EBD), HCBS-Community Mental Health Supports (CMHS), and HCBS Brain Injury (BI) waivers who reside in Alternative Care Facilities (ACF) and Supported Living Programs (SLP).

2. Case Management Responsibilities

a. For 300% eligible Members who reside in an Alternative Care Facility or Supported Living Program, the Case Manager shall complete the State-

prescribed form, which calculates the Member payment according to the following procedures:

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

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

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

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

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

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

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

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

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

4) Medications except for the following:

a) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be deducted from the Member's gross income.

b) The full cost of brand-name medications shall not be deducted from the member's gross income if a generic form is available at a lower price, unless the prescriber has specifically prescribed a name brand medication over the generic formula.

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

1) The need for such care must be documented in writing by the attending physician. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and shall be renewed whenever there is a change in the member's care needs, or if the member's needs do not change, annually.

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

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

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

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

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

xi. Any remaining income shall be applied to the per-diem cost of the Alternative Care Facility, as defined at Section 8.7506 or Support Living Program as defined at Section 8.7550 shall be paid by the Member directly to the Provider Agency.

xii. If income remains after the entire cost of Alternative Care Facility or Supported Living Program services is paid from the Member's income, the remaining income shall be retained by the Member and may be used at the Member's discretion.

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

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

c. The Case Management Agency shall maintain signed copies of Member payment forms in their files. The Case Management Agency shall provide a copy of the form to the Department upon request.

8.7202.CC PRIOR AUTHORIZATION REQUESTS (PAR)

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

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

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

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

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

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

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

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

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

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

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

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

9. REIMBURSEMENT

    a. Providers shall be reimbursed at the lower of:

        i. Submitted charges; or

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

    b. Claims for services are not reimbursable if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.7202.DD SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

1. The Service Plan Authorization Limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a Member's ongoing service needs within one service plan year.

2. 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.

3. 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.

4. 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.

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

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

a. If an Adverse Action occurs regarding a Member's HCBS waiver eligibility and/or services, the Case Manager shall send the Member their appeal rights as required at Sections 8.7202.R and 8.057.2.A.

7. 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.

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

i. The Member 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:

1) Medically fragile with skilled care needs;

2) Behavioral and/or Mental Health needs;

3) Criminal convictions and/or law enforcement involvement;

4) Homelessness;

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

6) Extreme danger to self/others;

7) Caregiver capacity or;

8) 1:1 supervision needed.

ii. The Member must demonstrate that less than 10% of current SPAL remains; or

iii. The Member 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 Member's regularly scheduled monitoring.

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

i. "Request for Exception Review Process" form;

ii. Service Plan;

iii. PAR; and,

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

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

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

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

ii. The URC shall complete the review in accordance with the timelines as identified in their contract.

d. 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.

e. 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.

8.7203 Case Manager Requirements and Responsibilities

8.7203.A Case Manager Requirements

1. The Case Manager(s) hired on or after October 8, 2021 shall meet minimum qualifications for HCBS Case Managers set forth in these regulations and shall be able to demonstrate competency in pertinent Case Management knowledge and skills.

2. All Home and Community-Based (HCBS) Case Managers must be employed by a contracted Case Management Agency. Case Management Agencies must maintain verification that employed Case Managers meet the minimum qualifications set forth in these regulations.

3. The minimum qualifications for HCBS Case Managers hired on or after October 8th, 2021 are:

a. A bachelor’s degree; or

b. Five (5) years of relevant experience in the field of Long-Term Services and Supports, 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.

4. Case Managers may not:

a. Be related by blood or marriage to the individual.

b. Be related by blood or marriage to any paid caregiver of the individual.

c. Be financially responsible for the individual.

d. Be the individual's legal Guardian, Legally Authorized Representative, Long-Term Services and Supports Representative, or Authorized Representative under Sections 8.7514 and 8.7527, or be empowered to make decisions on the individual's behalf through a power of attorney.

e. Be a provider for the individual, have an interest in, or be employed by a provider for the same individual. 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.

f. Be related by blood or marriage to the owner or managing employee of a provider.

5. Case Management Agency staff must pass competency-based training requirements as defined and enforced by the Department through contractual agreements.

6. The Case Management Agency supervisor(s) shall meet all qualifications for Case Managers and have a minimum of two years of experience in the field of HCBS Case Management.

8.7204 Functions of the Case Management Agency Supervisor

8.7204.A Supervision of Case Managers

1. Case Management Agencies shall provide adequate supervisory staff who shall be responsible for:

    a. Regular supervisory conferences with Case Managers on a regular basis related to their caseload and Members needs;

    b. Approval of indefinite lengths of stay in nursing facilities, determined according to Section 8.402.15;

    c. Regular, systematic review and remediation of case records and other Case Management documentation, on at least a sample basis;

    d. Communication with the Department when technical assistance is required by Case Managers and the supervisor is unable to provide answers after reviewing the regulations and other departmental publications;

    e. Allocation and monitoring of staff to assure that all standards and time frames are met; and

    f. Assumption of Case Management duties when necessary.

8.7204.B Training of Case Management Agency Staff

1. Case Management Agency staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for Case Management Agencies.

2. Prior to start-up, the Case Management Agency staff shall receive training provided by the Department or its designee, which shall include, but not be limited to, the following content areas:

    a. Background information on the development and implementation of the Case Management Agency system;

    b. Mission, goals, and objectives of the Case Management Agency system;

    c. Regulatory requirements and changes or modifications in federal and state programs;

d. Contracting guidelines, quality assurance mechanisms, and Certification requirements; and

e. Federal and state requirements for the Case Management Agency.

3. The Case Management Agency is responsible for tracking completion of required Case Management Agency training and staff development of program knowledge. Staff who require retraining or additional training shall receive training through available Department training and the Case Management Agency internal training.

4. Case Management Agency staff must pass competency-based training requirements as defined by the Department including but not limited to disability/cultural competency, person-centeredness, soft skills, as well as program specific knowledge and skills.

5. Case Management Agencies are responsible for providing quality oversight of their staff work product. At least quarterly, the Case Management Agency shall audit case records to evaluate Case Management performance. The Case Management Agency shall audit ten percent (10%) of the Case Management Agency average monthly caseload size or ten individual case records, whichever is higher.

a. The Case Management Agency shall utilize the audit form issued by the Department for Case Management Agency quality oversight audits.

b. The Case Management Agency shall audit each Case Manager employed by the Case Management Agency at least once per year.

c. The Case Management Agency shall provide the results of the audit to the Department and shall utilize audit results as part of the Case Management Agency quality assurance efforts.

8.7300 Community Centered Board

1. A Community Centered Board is the Agency, in addition to the Case Management Agency, responsible for leveraging local and regional resources to meet unmet needs for individuals with Intellectual and Developmental Disabilities (IDD) and their families

2. Beginning in 2024, at each Case Management Agency contract period or every ten years, whichever is longer, not for profit entities that have held a previous Community Centered Board designation and are seeking designation as a Community Centered Board, shall submit an application or request for designation to the Department.

3. Applications shall be submitted in a form and manner specified by the Department which shall be made available to Applicants upon request.

4. The Department shall notify all Applicants by email to the Community Centered Board (CCB) Executive Director of the designation or non-designation.

5. The designation shall be valid for up to a ten-year period based on Department approval.

6. Designation of a Community Centered Board shall be based on the following factor only:

   a. Prior Community Centered Board designation.

7. If no Agency requests the Community Centered Board designation in a defined service area, Community Centered Board (CCB) designation for that area will be discontinued for that defined service area.

8.7400 Home and Community-Based Services Provider Agency Requirements

8.7401 Statement of Purpose and Scope

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

8.7402 Definitions: Unless otherwise specified, the following definitions apply throughout Sections 8.7000-7500.

A. Case Manager is as defined in Section 8.7100.A.8.

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

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

D. Contractor is as defined at 8.7001.A.1-B.

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

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

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

H. Guardian is as defined at Section 8.7001.A.3-B.

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

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

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

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

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

N. Member is as defined at Section 8.7001.A.8-B.

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

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

Q. Prior Authorization Request (PAR) is as defined at 8.7202.B.

R. Protected Health Information (PHI) means individually identifiable health information, including, without limitation any information, whether oral or recorded in any form or medium that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information (PHI) includes, but is not limited to, any information defined as Individually Identifiable Health Information pursuant to 42 C.F.R. § 160.103.

S. Provider Agency is as defined at Section 8.7001.A.12-B.

T. Provider Care Plan means the documented approach the Provider Agency plans to take in the provision of services. The purpose of the Provider Care Plan is to outline the service(s) that will/is provided with corresponding functional goals and objectives that describes the need for the service and the anticipated benefit to the Member. The Provider Care Plan determines the focus of the services, while also documenting the scope, duration and frequency to which each service will be provided.

U. Provider Participation Agreement is as defined at Section 8.7001.A.14-B

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

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

8.7403 Provider Agency Certification, Decertification and Termination

A. Certification

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

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

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

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

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

a. Results of the initial survey;

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

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

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

B. Change in Information

1. Provider Agencies shall notify the Department of any material or substantial change in information contained in the enrollment application

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

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

C. Decertification

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

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

   b. The Provider Agency fails to comply with any lawful requests by the Department or its agents, including providing timely access to records.

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

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

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

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

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

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

8.7404 Change of Ownership

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

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

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

8.7405 Documentation

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

1. Incremental units of service

a. Location of service provided;

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

c. Name of individual rendering service;

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

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

f. Units of service provided.

2. Per-diem units of services

    a. Medication Administration Record if applicable;

    b. Daily attendance tracker; and

    c. Notes, which shall include:

        i. Activities Member participated in;

        ii. Respite services or overnight stays elsewhere if applicable.

8.7406 Insurance Requirements

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

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

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

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

2. Property damage $50,000, or

3. $500,000 combined single limit

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

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

2. Property damage $15,000.

8.7407 HCBS Provider Agency Billing

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

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

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

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

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

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

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

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

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

8.7408 Policies and Procedures

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

1. Staffing and employment

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

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

i. Responsibilities assigned to each employee job description.

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

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

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

2. Medication Administration

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

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

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

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

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

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

3. Protected Health Information (PHI)

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

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

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

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

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

i. Incident reports;

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

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

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

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

ii. A summary of the investigative procedures utilized;

iii. The full investigative finding(s); and

iv. The actions taken.

e. Provider Agencies shall

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

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

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

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

5. Protection of individual rights

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

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

6. Non-discrimination policies

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

7. Dispute resolution

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

        i. Who are found ineligible to receive the service(s) from the Provider Agency;

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

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

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

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

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

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

8. Grievances and Complaints

a. Provider Agencies shall have procedures setting forth a process for the timely resolution of Grievances or Complaints of Members, prospective Members, or Legally Authorized Representatives, as appropriate. Use of the Grievance/Complaint procedure shall not prejudice the future provision of appropriate services or supports. No individual shall be coerced, intimidated, threatened, or retaliated against because the individual has exercised his or her right to file a Grievance/Complaint or participate in the Grievance process.

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

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

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

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

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

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

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

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

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

9. Independent Contractors

a. Provider Agencies may utilize the services of independent Contractors at their discretion. If an Agency does utilize

independent Contractors, it shall conduct the vetting, training, and monitoring of, and take corrective action against Contractors.

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

10. Contingency planning

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

11. Telehealth

a. Provider Agencies that provide HCBS Telehealth services shall establish and maintain documented policies on the use of Telehealth services that comply with Section 8.7562.

12. Written Plans to Address Emergencies

a. An emergency can be defined as an unforeseen situation that may endanger the lives of Members and/or staff, as well as disrupt for a short time the normal operations within a setting or Agency.

b. Emergencies can include, but are not limited to:

i. Medical Emergencies

ii. Public Health Emergencies

iii. Fire

iv. Natural Disasters

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

i. Plans should include how the agency prepares for loss of staff, various emergencies, back up plans, protocols, etc. should any staff be affected.

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

8.7409 Personnel

A. Employee and Contractor records

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

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

a. Documentation of qualifications.

b. Documentation of trainings completed.

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

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

e. Documentation of the job description or signed contract.

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

B. License/Certification

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

C. Medication administration

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

D. Trainings

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

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

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

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

    d. Provider Agencies' internal policies and procedures.

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

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

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

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

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

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

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

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

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

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

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

8.7410 Rendering services according to the Person-Centered Support Plan

A. Provider Agencies shall provide all Provider Agencies identified in the Person-Centered Support Plan (PCSP) a copy of the PCSP. Provider Agencies shall maintain this plan on file and ensure it is accessible to all staff who need it.

B. Provider Agencies shall utilize the Person-Centered Support Plan as the basis for completing a Provider Care Plan. Any member of the Member Identified Team should be included in the development of the Provider Care Plan.

C. Provider Care Plan

1. All Provider Agencies identified in the Person-Centered Support Plan shall develop a Provider Care Plan for each Member.

2. The Provider Care Plan should, at a minimum, identify the following:

a. The service and care needs of the Member;

b. Provider Care Plan development date;

c. Goals or Objectives of the service(s);

d. A description of the specific services, supports, methodologies or interventions used to address the identified needs of the Member, written in plain language including;

i. information about the Member's preferences

ii. relevant medical information from medical and therapy providers (PCP, OT, PT, Speech, etc.)

g. Duration: Describes how long the service will be delivered, with the duration of the service corresponding to the abilities of the Member and is reflective of the billing unit identified by service; and

h. Frequency: Identifies how often the service or support will be offered to the Member, according to their needs and preferences.

3. The Provider Care Plan shall assure the protection of the rights of Members as defined by the Department under applicable programs, including but not limited to Section 8.7001, et seq.

4. Provider Agencies shall follow specific service or care plan regulations for each covered benefit they render to a Member. Provider Care Plans may vary by name depending on the covered benefit, but will describe the information outlined above.

5. The Provider Care Plan shall be reviewed at least two times a year. as needed, to determine:

a. The results achieved;

b. If the needs of the Member are accurately reflected in the Provider Care Plan;

c. Whether the services and supports identified in the Provider Care Plan are appropriate to meet the Member's needs as assessed in the Person-Centered Support Plan; and

d. What actions are necessary for the Provider Care Plan to be successfully implemented.

D. Members receiving services shall be included in developing the Provider Care Plan and have the freedom to choose from willing Provider Agencies.

E. Provider Agencies shall coordinate with other Provider Agencies, when applicable.

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

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

8.7411 Incident Reporting

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

1. Death of Member receiving services;

2. Hospitalization of Member receiving services;

3. Medical emergencies, above and beyond first aid;

4. Allegations of MANE;

5. Injury to Member or illness of Member;

6. Damage or theft of Member's personal property;

7. Errors in medication administration;

8. Lost or missing person receiving services;

9. Criminal activity; and

10. Incidents or reports of actions by Member receiving services that are unusual and require review.

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

1. Name of person reporting;

2. Name of Member who was involved in the Incident;

3. Member's Medicaid identification number;

4. Name of persons involved or witnessing the Incident;

5. Incident type;

6. Date, time, and duration of Incident;

7. Location of Incident;

8. Persons involved;

9. Description of Incident;

10. Description of action taken;

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

12. Name of person notified;

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

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

15. Resolution, if applicable.

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

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

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

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

8.7412 Environmental Standards for Provider-Owned or -Controlled Settings

A. Provider Agencies shall ensure that Provider-Owned or -Controlled Settings defined at Section 8.7001.A.13 and .14 shall comply with all the environmental standards outlined below, in addition to the requirements set forth in Section 8.7001.B

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

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

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

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

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

8.7413 Room and Board

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

1. Alternative Care Facility
2. Supportive Living Program
3. Transitional Living Program
4. Individual Residential Service and Supports
5. Group Residential Services and Supports
6. Children's Habilitation Residential Program Out-of-Home residential settings
7. Mental Health Transitional Living Homes

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

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

8.7414 Medication Administration

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

1. No prescription medication shall be administered without a written order by a licensed medical professional. Medications/prescriptions shall be reviewed by a licensed medical professional annually, or more frequently if recommended by the licensed medical professional or required by law.
2. The Provider Agency shall ensure that a Member's refusal to take medication(s) and/or any adverse reaction to a medication are

documented in the Member's medication administration record and reported to the Member's licensed medical provider.

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

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

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

C. CHRP Medication Administration

1. If medications are administered to a Member during the course of HCBS-CHRP service delivery the following shall apply:

a. Medications must be prescribed by a licensed medical professional. Prescriptions and orders must be kept in the Member's record.

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

c. CHRP Habilitation Provider Agencies providing Foster Care Homes, Kinship Foster Care Homes, 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.

f. Host Homes Provider Agencies and Contractors must comply with the requirements for the use of medication administration at Section 8.7414 for Members aged 18 to 20 years receiving Habilitation services.

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

8.7415 Psychotropic Medications

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

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

2. After informed consent of the Member or Legally Authorized Representative has been obtained.

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

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

2. Be administered per prescriber's orders;

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

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

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

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

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

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

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

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

C. Gastrostomy services shall not be administered by an unlicensed individual unless that individual is trained and supervised by a licensed physician, nurse, or other practitioner. The licensed nurse, physician or other practitioner overseeing

the initial and periodic training shall document in the employee or Contractor record:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The amount of nutrient or fluid intake;

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

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

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

8.7417 Telehealth

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

8.7418 Base Wage Requirement for Direct Care Workers

A. Base Wage Requirement for Direct Care Workers Definitions

1. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of Home and Community-Based Services (HCBS) required by the Colorado Department of Health Care Policy and Financing.

2. Direct Care Worker is as defined in Section 8.7402.F.

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

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

providing a higher wage, or otherwise setting a higher standard, shall apply.

5. Plan of Correction means a formal, written response from a Provider Agency to the Department on identified areas of non-compliance with requirements listed in Section 8.7418.D.

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

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

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

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

   a. Adult Day Services

   b. Alternative Care Facility (ACF)

   c. Community Connector

   d. Consumer Directed Attendant Support Services (CDASS)

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

   f. Group Home Habilitation (CHRP)

   g. Group Residential Support Services (GRSS)

   h. Homemaker

   i. Homemaker Enhanced

   j. Host Home (CHRP)

   k. In-Home Support Services (IHSS)

l. Individual Residential Support Services (IRSS)

m. Job Coaching

n. Job Development

o. Mental Health Transitional Living Homes

p. Mentorship

q. Pediatric Personal Care

r. Personal Care

s. Prevocational Services

t. Respite

u. Specialized Habilitation

v. Supported Community Connections

w. Supported Living Program

x. Workplace Assistance

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

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

C. Base Wage Provider Agency Responsibilities

1. A Provider Agency 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.

2. The Provider Agency must ensure that contact information on file with the Department is accurate.

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

4. Provider Agencies 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.

5. Provider Agencies 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. Provider Agencies shall submit the requested information within the Department-specified timeframe.

6. Provider Agencies 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.

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

    a. Payroll summaries and details, pay stubs with details

    b. Timesheets

    c. Paid time off records

    d. Cancelled checks (front and back)

    e. Direct deposit confirmations

    f. Independent Contractor documents or agreements

    g. Per diem wage documents

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

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

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

2. Provider Agencies shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by

the Department. Incomplete or invalid submissions will be returned to Providers for corrections.

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

4. If a plan of correction is requested by the Department, the Provider Agency shall submit the plan of correction by the date specified by the Department. The Provider Agency 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 Agency must explain the reason for the delay and the Department may or may not grant an extension in writing.

5. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider 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.

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

8.7419 Home and Community-Based Services Weekly Caregiver Limits

1. Definitions

a. Caregiver means any individual that is paid to provide Qualifying Services as defined at Section 8.7419.1.s. This term also includes Direct Care Worker (DCW), defined at 8.7402.F, and any other individuals paid to perform such services.

b. Caregiver Compliance Attestation refers to the annual attestation each Provider Agency or FMS is required to obtain from each individual Caregiver and maintain.

c. Caregiver Compliance Review refers to the Department's oversight to ensure Caregivers, Provider Agencies, CDASS Employers, and FMS Contractors are complying with State laws and regulations.

d. Caregiver Compliance Workbook refers to the Department-approved workbook that details the days worked, number of hours worked, services

provided, the number of members served by the Caregiver during the requested time period, and other relevant information that the Provider Agency, Caregiver, CDASS Employer, Department, and/or FMS vendor deem necessary for the Department to complete a compliance review.

e. Case Management Agency as defined in Section 8.7100.A.8

f. Case Manager as defined in Section 8.7200.B.5.

g. Consumer-Directed Attendant Support Services Authorized Representative as defined in Section 8.7515.B.5.

h. Consumer-Directed Attendant Support Services (CDASS) Employer means a Member enrolled in CDASS or their Authorized Representative, who is the legal employer of record for CDASS.

i. Emergency Situation means an unanticipated, short-term event that results in the immediate unavailability of a scheduled Caregiver and creates a risk to the member's health, safety, or ability to remain in their home if services are not provided. In an Emergency Situation, a Caregiver may temporarily exceed the Weekly Caregiver Limit or the Per Day Hourly Limit per member to prevent a disruption in critical direct care service. The Emergency Situation must:

    i. Be unexpected and not routinely foreseeable,

    ii. Be time-limited in duration to no more than 7 calendar days from the onset of the emergency,

    iii. Be necessary to address an immediate need,

    iv. Be used solely to prevent a gap in critical services, and

    v. Be documented in the Member's file and maintained by the Provider Agency or FMS.

j. Enforcement means withholding of claim payments and/or recoupment of Medicaid funds for noncompliance with this rule.

k. False Representation means an inaccurate statement made by the Caregiver, Provider Agency, CDASS Member or Authorized Representative, or FMS Contractors that is relevant to a claim for reimbursement.

l. Financial Management Services (FMS) Contractors as defined in Section 8.7515.B.15.

m. In-Home Support Services Authorized Representative as defined at Section 8.7528.B.2.

n. Payment Hold Enforcement refers to the Department withholding claim payments to Provider Agencies or FMS Contractors for noncompliance with this rule.

o. Per Day Hourly Limit means the maximum number of hours a Caregiver may work and be reimbursed for in a single calendar day, from 12:00 a.m. through 11:59 p.m. A Caregiver may not be scheduled for, provide, or receive reimbursement for more than sixteen (16) total hours of care in a calendar day across any combination of the following services, whether provided to one or more Members collectively, unless permitted due to a documented Emergency Situation:

   i. Consumer Directed Attendant Support Services as defined at Section 8.7515,

   ii. In-Home Support Services as defined at Section 8.7528,

   iii. Personal Care as defined at Section 8.7538,

   iv. Homemaker as defined at Section 8.7527,

   v. Health Maintenance Activities as defined at Section 8.7523,

   vi. Long-Term Home Health as defined at Section 8.520, and/or

   vii. Private Duty Nursing as defined at Section 8.540.

p. Provider Agency: For purposes of Section 8.7419, Provider Agencies include HCBS provider agencies as defined at Section 8.7001.A.12-B and Home Health Agencies as defined at Section 8.520.1.L.

q. Provider Agency Caregiver Attestation refers to the annual attestation that Provider Agencies or CDASS Employers are required to sign and maintain. The FMS must retain copies of the signed attestation for each CDASS Employer. This attestation is a signed statement for the Provider Agency or CDASS Employer stating they understand that they are responsible for overseeing each Caregiver and must hold each Caregiver accountable to the Per Day Hourly Limit and Weekly Caregiver Limit, including any limit violations.

r. Qualifying Services include:

   i. Consumer Directed Attendant Support Services as defined at Section 8.7515,

ii. In-Home Support Services (IHSS) as defined at Section 8.7528,

iii. Personal Care as defined at Section 8.7538.

iv. Homemaker Services as defined at section 8.7527

v. Health Maintenance Activities as defined at Section 8.7523

vi. Long-Term Home Health Nursing Services as defined at Section 8.520.5.A.

vii. Certified Nurse Aide Services as defined at Section 8.520.5.B

s. Rural or Frontier means counties or communities classified by the Colorado Rural Health Center in the County Designations system (see Colorado Rural Health Center, "Maps," available at https://coruralhealth.org/resources/maps-resource).

t. Weekly Caregiver Limit means the maximum number of hours of Qualifying Services a Caregiver can provide to one Member in any week, from 12:00 a.m. Sunday to 11:59 p.m. Saturday. Unless documented by a pending or approved Weekly Caregiver Limit Exception Request, or in a documented Emergency Situation, no individual Caregiver must be scheduled or work more than the following maximum hours:

i. Between July 1, 2026 and December 31, 2026: 84 hours per week;

ii. Between January 1, 2027 and June 30, 2027: 70 hours per week; and

iii. From July 1, 2027 and ongoing: 56 hours per week.

u. Weekly Caregiver Limit Exception Request means a formal request submitted by a Provider Agency or CDASS Employer when an individual Caregiver must exceed the Weekly Caregiver Limit because the Member meets one of the criteria described in Section 8.7419.2. The request must include required supporting documentation provided by the Provider Agency or CDASS Employer.

2. Weekly Caregiver Limit Exception Request

a. An exception to the Weekly Caregiver Limit will only be approved if the Member meets one of the following criteria:

i. Extraordinary clinical acuity, which means the Member has a complex diagnosis which results in medical fragility, creates severe risk of hospitalization or death, requires strict limitation of close

contact that cannot be reasonably mitigated by personal protective equipment, and is supported by clinical documentation.

ii. Demonstrated workforce access barriers, which requires meeting the criteria under Section 8.7419.2.a.ii.1 and 8.7419.2.a.ii.2:

1) Demonstrated workforce access barrier requires one of the following:

a) The Member lives in a Rural or Frontier area and documented recruitment efforts demonstrate an inability to recruit or retain qualified Caregivers through the local Medicaid workforce; or

b) The Member requires documented specialized skills not reasonably available through Medicaid workforce and for which a new Caregiver could not reasonably be trained within the timeframe necessary to safely meet the Member's needs; or

c) The Member can only communicate using an uncommon language and requires a Caregiver who speaks the same uncommon language. An uncommon language means a language for which qualified Caregivers are not reasonably available within the Member's service area, as demonstrated by documented recruitment efforts and limited local provider capacity. Individualized communication preferences or familiarity with a specific Caregiver alone do not constitute sufficient justification for an exception.

2) All demonstrated workforce access barriers require multiple recruitment attempts that have failed despite documented outreach. Recruitment and retention efforts must demonstrate ongoing attempts to identify and maintain qualified caregivers appropriate to meet the member's assessed needs. At a minimum, documentation must include one or more of the following:

a) At least two (2) documented recruitment attempts conducted over a period of at least 30 calendar days through formal outreach methods such as job postings; or

b) Documentation of at least two (2) unsuccessful caregiver retention efforts resulting in service

disruption or inability to safely maintain staffing necessary to meet the Member's assessed needs.

iii. Transition or stabilization periods, which includes one or more of the following:

1) Following a hospital discharge within the past 30 days; or

2) During a stabilization period following a Crisis, as defined at Section 8.7100.A.18; or

3) While a Provider Agency or CDASS Employer recruits and trains additional staff following the loss, long-term illness, resignation, or termination of a Caregiver.

iv. End-of-life circumstances, where stability and continuity with a primary caregiver is clinically appropriate and supported by clinical documentation, and is due to a Member's need to have strict limitation of contact which cannot be reasonably mitigated by personal protective equipment, and requires one of the following:

1) The Member has a terminal illness, which means a medical prognosis of life expectancy of nine months or less as documented by a physician; or

2) For Members under 19 years of age, the Member has a diagnosis of a life-limiting illness (i.e. a life-limiting medical condition or set of life-limiting medical conditions) as certified by a licensed medical professional and documented as prescribed by the Department.

b. In each Weekly Caregiver Limit Exception Request, the submission must include all of the following and be supplied by the Provider Agency or CDASS Employer:

i. Member-specific documentation, including documented diagnoses, functional/medical necessity and/or acuity;

ii. Risks and consequences to the Member if the exception is not granted;

iii. The following, as applicable:

1) Evidence of the extraordinary clinical acuity criteria met by the Member as described at Section 8.7419.2.a.

a) Documentation to support the demonstrated workforce access barriers as described at Section 8.7419.2.a.

b) Discharge summaries or crisis plans, and need for continuity of Caregiver.

c) End-of-Life diagnosis and need for continuity of care.

d) Documentation to support the diagnosis of a terminal illness or life-limiting illness and the criteria described at Section 8.7419.2.a.

e) If applicable, the number of live-in caregivers and family caregivers scheduled to provide services to the Member;

i. Additional hours requested for the Caregiver beyond the Weekly Caregiver Limit, Provider Agency or CDASS Employer name, and the name/relationship of the Caregiver;

ii. A summary of:

1) The number of Members the Provider Agency or CDASS Employer serves, and

2) The number of Caregivers employed by or contracted with for all Members served by the Provider Agency or CDASS Employer.

iii. How the Provider Agency or CDASS Authorized Representative has ensured informed consent and/or choice, if other Provider Agencies exist in the Member's geographical area;

iv. How the Provider Agency or CDASS Employer continues to support the recruitment of willing and qualified caregivers in the Member's geographical area;

v. Policies in place to ensure Member safety with extended Caregiver hours;

vi. Any additional information requested by the Department that is necessary to substantiate the need for the exception; and

vii. For Members on Community First Choice or Community First Choice and Long-Term Home Health, the Members Case Management Agency, the Case Manager's name and contact information.

c. Provider Agency or CDASS Employer Responsibilities re: Weekly Caregiver Limit Exception Request

i. All Weekly Caregiver Limit Exception Requests must be submitted to the Department as soon as the need for an exception arises, and whenever possible, at least 30 calendar days prior to the service start date. Provider Agencies or CDASS Employers are responsible for following Case Management Agency and Department prescribed timelines.

ii. Provider Agencies or CDASS Employers serving Members on the following programs must submit the request and all relevant documentation to the Department. Prior to submission to the Department, the Provider Agency must inform the Member's Case Manager.

1) Community First Choice, and

2) Community First Choice and Long-Term Home Health.

iii. Home Health Provider Agencies who provide services to Members who only receive Long-Term Home Health, and who do not have a Case Management Agency's involvement, must submit Weekly Caregiver Limit Exception Requests directly to the Department.

iv. Provider Agencies or CDASS Employers are responsible for responding to requests for additional information within 7 calendar days. If additional information is not provided to the Department within 7 calendar days, the Department will issue a decision based on the information that was initially provided.

v. Caregivers for Members with a submitted Weekly Caregiver Limit Exception Request are not required to follow the Weekly Caregiver Limit until seven (7) calendar days after the Weekly Caregiver Limit Exception Request has been approved or denied by the Department.

a. An exception request is considered submitted once it has been completed by the Provider Agency or CDASS Employer and submitted to the Department.

1) Provider Agencies or FMS Contractors must maintain documentation of the completed submission for their records. FMS Contractors will be provided a copy of the approved or denied Weekly Caregiver Limit Exception request by the Department.

b. Provider Agencies, FMS Contractors, CDASS Employers, and Caregivers must comply with the determination of the exception request within 7 calendar days of the decision being issued by the Department.

c. Provider Agencies, Caregivers, CDASS Employers, and Case Managers to the extent applicable under Section 8.7202.B.5, must actively work to secure alternative staffing while the Weekly Caregiver Limit Exception Request is under review. The submission of an exception request does not guarantee approval and cannot substitute for ongoing recruitment and staffing efforts.

vi. Caregivers who provide services to more than one Member must comply with the Weekly Caregiver Limit separately for each Member served. A Caregiver may provide up to the Weekly Caregiver Limit for each Member, provided that the Caregiver does not exceed the Per Day Hourly Limit defined at Section 8.7419.1.b across all Members served collectively.

vii. If the Weekly Caregiver Limit Exception Request is denied by the Department, the Provider Agency or CDASS Employer that submitted the request may not submit a new request unless there is (1) a change in circumstance or condition and (2) new documentation that supports the Weekly Caregiver Limit Exception Request Criteria as described at Section 8.7419.2.a.

viii. Provider Agencies or CDASS Employers are responsible for informing Caregivers of Weekly Caregiver Limit Exception Request information and decisions of exception requests.

ix. Weekly Caregiver Limit Exception Requests are applicable to the Caregiver. The Caregiver is responsible for disclosing all hours to each Provider Agency or CDASS Employer through which they provide services. If a Provider Agency or CDASS Employer employs or contracts with a Caregiver who discloses they work with two or more Provider Agencies, the Provider Agency or CDASS Employer must coordinate with all other Provider Agencies or CDASS Employers that employ or contract with the Caregiver when submitting a Weekly Caregiver Limit Exception Request. The CDASS Employer may request assistance with coordination through the Member's Case Manager.

x. Each approved Weekly Caregiver Limit Exception Request is valid until the Prior Authorization Request (PAR) end date. If a Weekly Caregiver Limit Exception Request is approved within 60 days prior

to the PAR end date, the Weekly Caregiver Limit Exception Request will be valid until the following PAR end date.

a. A Weekly Caregiver Limit Exception Request may be submitted at any time.

d. Case Manager Responsibilities for Weekly Caregiver Limit Exception Requests

i. Case Managers must review Weekly Caregiver Limit Exception Requests submitted by Provider Agencies or CDASS Employers within seven (7) calendar days. The Case Manager must submit an attestation for the Weekly Caregiver Limit Exception Request using the process prescribed by the Department.

ii. The Department retains final authority regarding approval or denial of Weekly Caregiver Limit Exception Requests.

iii. Case Management Agencies must document all coordination and communication related to the Weekly Caregiver Limit Exception Request in the Care and Case Management (CCM) system.

e. Department Responsibilities for Weekly Caregiver Limit Exception Requests

i. The Department will review Weekly Caregiver Limit Exception Requests for:

1) Thoroughness of documentation, including evaluating documentation to support member-specific needs;

2) Validation of the risks to the Member if the exception is not granted, which must be clearly identified and substantiated;

3) Justification that the requested exception to the Weekly Caregiver Limit is necessary to safely and effectively meet the member's already assessed and authorized service needs;

4) Assessment of workforce availability and documented recruitment efforts, where applicable. The Department will consider the Member’s geographic location, living situation, acuity, communication needs, and other relevant circumstances when evaluating workforce access barriers and recruitment efforts;

5) Confirmation that the request meets at least one exception category;

6) The manner in which the Weekly Caregiver Limit Exception Request maintains the Member's health and safety and promotes sustainable community-based living.

f. The Department will approve Caregiver Limit Exception Requests on a case-by-case basis when a demonstrated need is documented and justified by the Member's Provider Agency or CDASS Employer and sufficiently meets the review criteria outlined at Section 8.7419.2.

g. The Department will provide an initial response to the Provider Agency or CDASS Employer regarding the Weekly Caregiver Limit Exception Request within 14 calendar days. If additional information is needed for the Department to process the Weekly Caregiver Limit Exception Request, a request for additional information will be provided to the submitting Provider Agency or CDASS Employer. If additional information is not provided to the Department within 7 calendar days, the Department will issue a decision based on the information that was initially provided.

h. The Department must issue a determination letter for each Weekly Caregiver Limit Exception Request unless the Weekly Caregiver Limit Exception Request is withdrawn by the Provider Agency CDASS Employer. Each determination letter must include the following and be provided to the Provider Agency or CDASS Employer and FMS Contractor, and the Case Manager:

i. The type of exception that was requested;

ii. The amount requested by the Provider Agency or CDASS Employer;

iii. The approved, partially approved, or denied weekly Caregiver hours;

iv. A summary of the documentation reviewed, including the Person Centered Support Plan (PCSP), as defined at Section 8.7200.B, and supporting justification; and

v. The regulatory citation(s) to support the decision.

i. The Weekly Caregiver Limit Exception Request process must be implemented in a uniform manner applied to Members statewide, but decisions must be based on individual assessed needs and circumstances.

3. Weekly Caregiver Limit Enforcement

a. Case Manager Enforcement Responsibilities

i. For applicable Weekly Caregiver Limit Qualifying Services, Case Managers must inform Members of this requirement during the PCSP process as defined at Section 8.7200.B.

ii. As appropriate pursuant to Section 8.7202.J.6, Case Managers must assist Members in identifying alternative Provider Agencies or alternative service delivery options when the Member does not have access to adequate Caregivers through their current Provider Agency or service delivery option and must document this assistance in the Member's record.

iii. Case Managers must assist Members and Authorized Representatives in identifying whether a Weekly Caregiver Limit Exception Request may be necessary to prevent disruption of authorized services, including during the Person-Centered Support Planning process, hospital discharge planning, crisis stabilization, provider transition, or reported caregiver shortage.

b. Provider Agency or CDASS Employer and FMS Contractor Enforcement Responsibilities

i. The Provider Agency or FMS Contractor must obtain a Caregiver Compliance Attestation. Each Caregiver Compliance Attestation must include:

1) A signed statement from each individual Caregiver stating they will not work more than the Per Day Hourly Limit or Weekly Caregiver Limit per Member except with a pending or approved Weekly Caregiver Limit Exception Request, or in a documented Emergency Situation.

2) A Caregiver disclosure of every Provider Agency they are employed by and update this information if it changes.

ii. The Caregiver Compliance Workbook must be provided to the Department upon request and completed for the requested time period. The Caregiver Compliance Workbook is in addition to, and not a substitution for, any record keeping required by the Caregiver's professional standards of practice, if applicable.

iii. For the purposes of Members not enrolled in CDASS, the following requirements are applicable to Provider Agencies:

1) The Provider Agency must ensure that individual Caregivers are not scheduled or reimbursed for more than the Per Day Hourly Limit except in a documented Emergency Situation.

2) For all Members cared for by a Provider Agency, the Provider Agency must ensure that individual Caregivers are not scheduled or reimbursed for more than the Weekly Caregiver Limit across Qualifying Services except in a pending or approved Weekly Caregiver Limit Exception Request or in a documented Emergency Situation.

a) A Caregiver that renders services subject to the Per Day Hourly Limit must ensure the Per Day Hourly Limit is not exceeded. Exceptions to the Per Day Hourly Limit must be supported by a documented explanation of an Emergency Situation.

b) A Caregiver that renders Qualifying Service(s) must ensure the Weekly Caregiver Limit is not exceeded. Exceptions to this limit must be supported by a documented pending or approved Weekly Caregiver Limit Exception Request.

iv. For the purposes of CDASS, Weekly Caregiver Limit Provider Agency Responsibilities outlined in 8.7419.3 are the responsibility of the CDASS Employer and the Financial Management Services Contractor and are allocated as follows:

1) CDASS Employer Responsibilities:

a) Inform Attendants of the Per Day Hourly and Weekly Caregiver Limits;

b) Ensure Attendants are scheduled in compliance with the Per Day Hourly and Weekly Caregiver Limits, except in a documented Emergency Situation, or with a pending or approved Weekly Caregiver Limit Exception Request;

c) Approve accurate service hours records in FMS Contractor’s timesheet system for proper payroll processing;

d) Monitor Attendant hours and work schedules to prevent exceedances;

e) CDASS Employers must maintain sufficiently qualified Caregivers to ensure compliance with caregiver limits while continuing to meet the Member’s authorized service needs;

f) Provide necessary and accurate information and documentation to support compliance with the limits, including documentation for Weekly Caregiver Limit Exception Requests and Emergency Situations, when applicable.

1) Financial Management Services (FMS) Contractor Responsibilities:

a) Monitor and enforce the Per Day Hourly and Weekly Caregiver Limits through timesheet, payroll and claims processing systems;

b) Prevent reimbursement for hours that exceed allowable limits, unless supported by a pending or approved exception or documented Emergency Situation;

c) Process and retain documentation required under this section, including exception requests, attestations, and compliance records; and

d) Provide records and documentation to the Department upon request in accordance with Section 8.7419.4.

4. Compliance Review Requirements

a. Provider Agencies, CDASS Employers, and FMS Contractors are responsible for developing policies and procedures to comply with Section 8.7419.

b. Provider Agencies and CDASS Employers are obligated to compensate Caregivers for all hours worked in accordance with applicable state and federal labor laws, regardless of Medicaid reimbursement limitations or claim payment determinations.

c. Provider Agencies, CDASS Employers, and FMS Contractors must keep true and accurate records to support and demonstrate that the Per Day Hourly Limit and the Weekly Caregiver Limit are not exceeded. Any exceedance must be supported by an approved or pending Weekly Caregiver Limit Exception Request or a documented explanation of an Emergency Situation.

d. The Provider Agency or FMS Contractor must retain records in accordance with sections 8.130.2 and 8.7405 and must make records available for inspection by the Department upon request. In addition to the

documentation required by 8.130.2 and 8.7405, Provider Agencies must retain:

i. Provider Agency Caregiver Attestation and Caregiver Compliance Attestation.

ii. Documentation to support an Emergency Situation that requires an exception to the limit.

iii. Paystubs reflecting, at a minimum, hours worked, pay period, and tax year.

iv. Independent Contractor documents or agreements.

v. Accounting records such as accounts receivable and accounts payable.

vi. Submitted, approved, and denied Weekly Caregiver Limit Exception Requests.

e. The Department may request information regarding Caregiver hours at any time.

i. The Provider Agency or FMS Contractor, must submit specific information regarding each Caregiver's working hours, work location, services provided, Members served, submitted Weekly Caregiver Limit Exception Requests, Caregiver Compliance Workbook, and documented Emergency Situations to support exceeding the limit if applicable, and any other related information as requested by the Department.

ii. Provider Agencies or FMS Contractors must submit the requested information within 10 business days and in the format requested by the Department. Submitted information must be complete, clear, understandable, readable, and auditable.

f. Failure to submit information as required, failure to provide adequate documentation, False Representation, or failure to provide timely responses may result in the Department suspending payment of claims to the Provider Agency or FMS Contractor until the requested information is received and reviewed by the Department.

g. The Department may perform Caregiver Compliance Reviews related to Caregiver Compliance Attestations, Caregiver Compliance Workbook, and/or other relevant documents. Failure to submit information as required or failure to provide adequate documentation within the specified timeframe may result in the Provider Agency or FMS Contractor being

required to submit a written response, as defined at Section 8.076.6 and/or be subject to an overpayment or penalty recovery.

i. If a written response is requested by the Department, the Provider Agency or FMS Contractor must submit the response by the date specified by the Department. The Provider Agency must notify the Department in writing within ten (10) business days of receipt of the request if it will not be able to meet the deadline. The Provider Agency or FMS Contractor must explain the reason for the delay. The Department may or may not grant an extension, and will communicate its decision in writing.

h. Upon the Department's receipt of the written response, 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 Agency or FMS Contractor must resubmit a new Plan of Correction along with any requested documentation to the Department for review within ten (10) business days of notification. Failure to complete the Plan of Correction as required may result in a Payment Hold Enforcement, an overpayment or penalty recovery, or termination from participation in Colorado Medicaid.

i. If the Department determines the limits were exceeded without a documented Emergency Situation or a pending or approved Weekly Caregiver Limit Exception Request, the Department will issue an adverse action letter to the Provider Agency or FMS Contractor. The Provider Agency or FMS Contractor will have no more than 30 calendar days to respond to the letter with payment or an informal reconsideration request. The Provider Agency or FMS Contractor will also have appeal rights before any recoupment from the Provider Agency or FMS Contractor by the Department is made.

j. The Department is authorized under C.R.S. Section 25.5-4-301(1) to assess, enforce, and collect penalties for noncompliance with statutes and regulations

k. Any payment to a Provider Agency for caregiver hours worked in excess of the Per Day Hourly Limit or the Weekly Caregiver Limit, or for hours that are not adequately documented as being compliant with the limits, is an overpayment subject to recoupment. FMS Contractor claims will be recouped if the FMS fails to meet the requirements of Section 8.7419.3.b.ii.2, resulting in CDASS caregiver hours being processed and paid beyond the allowed limits without adequate documentation demonstrating exception compliance.

l. An overpayment is the result of the Provider Agency or FMS Contractor providing inaccurate statements that are relevant to a claim for

reimbursement or failing to accurately maintain and/or process records required by the Department or failing to become familiar with rules, manuals, and bulletins issued by the Department or the Department's fiscal agent (see C.R.S. 25.5-4-301(2)). Any misleading or false information supplied by a CDASS employer to the FMS Contractor for a Weekly Caregiver Limit Exception Request or for verifying an Emergency Situation occurred may lead to the FMS Contractor being permitted by the Department to seek subsequent recoupment of overpayment from the CDASS employer and/or employer's employees.

m. Noncompliance issues can result in a claim payment hold, an overpayment recoupment, or termination from participation in Colorado Medicaid. Issues of noncompliance include the following:

i. Failure to meet Department specified deadlines for submitting documentation and/or responses to Department requests for information.

ii. Failure to maintain supporting documentation as required.

iii. Failure to submit supporting documentation that is readable, auditable, complete, or in the requested format.

iv. Failure to create and submit a Plan of Correction if requested by the Department.

v. Failure to accurately bill Medicaid for rendered services.

vi. Failure to comply with the Daily Caregiver Limit.

vii. Failure to comply with the Weekly Caregiver Limit.

8.7500 HCBS Benefits and Services Requirements

8.7501 Statement of Purpose and Scope

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

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

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

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

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

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

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

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

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

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

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

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

K. Direct Care Services Calculator (DCSC) means the Department's required service planning assessment tool used by a Case Manager to determine and document the number of hours of Personal Care, Homemaker, and Health Maintenance Activities a Member needs, as informed by Task Standards/Age-Appropriate Task Standards and documented need The DCSC includes task definitions, Age-Appropriate Task Standards for Children, Task Standards for Adults, the CFC HMA Documentation Guide, and embedded 'exception' triggers that identify when additional service hours require additional justification and supervisor approval and/or HCPF approval through the CFC Direct Care Services Exception Process. Case Managers must utilize the Task Standards for Adults and the Age-Appropriate Task Standards for Children provided by the

Department to establish appropriate service authorization for members. An up-to-date version of the DCSC can be found on the Department website.

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

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

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

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

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

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

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

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

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

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

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

W. Legally Responsible Person means any person who has legal responsibility to care for another person. For children, this includes the parent or legal guardian of a minor child. For adults, this is limited to the Member's spouse (by marriage or Common Law Marriage as defined at Section 8.100) and does not include the parent or legal guardian of an adult.

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

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

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

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

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

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

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

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

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

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

HH. Age-Appropriate Task Standards for Children establish expected levels of assistance, participation, or contribution for children from birth through age 18, based on typical developmental abilities within defined age ranges. These standards are used to determine the portion of Homemaker, Personal Care, and Health Maintenance Activities that a child without a disability would reasonably be expected to perform, and therefore the amount of time that may be authorized for a provider to complete tasks the child is unable to perform due to a disability. The combined total of all task maximums represents the Annual CFC Service Soft Caps, and any amount exceeding the Annual CFC Service Soft Caps requires Department approval. Age-Appropriate Task Standards for Children are parameters designed to facilitate a conversation between Case Managers and Members and are not the exclusive factor in determining a Member's task and service allocations. Case Managers cannot exceed the maximum allowed time without receiving approval from a Supervisor or Alternative Qualified Professional, as described in Section 8.7607.A.3.

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

JJ. Task Standards for Adults establish the amount of time associated with the level of assistance, effort, or support an adult is reasonably expected to require or contribute to complete tasks, based on typical functional abilities for adults without impairments. These standards are based on general evidence-based guidelines of typical functional abilities for adults without impairments. These standards are used to determine the portion of Homemaker, Personal Care, and Health Maintenance Activities that an adult without a disability would reasonably

be expected to perform, and therefore the amount of time that may be authorized for a provider to complete tasks the adult is unable to perform due to a disability. The combined total of all task maximums represents the Annual CFC Service Soft Caps, and any amount exceeding the Annual CFC Service Soft Caps requires Department approval. Task Standards are parameters designed to facilitate a conversation between Case Managers and Members and are not the exclusive factor in determining a Member's task and service allocations. Case Managers cannot exceed the maximum allowed time without receiving approval from a Supervisor or Alternative Qualified Professional, as described in Section 8.7607.A.3.

KK. Parental or Legal Guardian of a Minor Responsibility means the legal rights and duties held by a parent or by a court-appointed legal guardian to provide for the physical, emotional, developmental, and functional well-being of a child under age 18, including the responsibility to assist with or oversee activities of daily living and instrumental activities of daily living necessary for the child's development. When determining service needs for children, Case Managers must utilize Age-Appropriate Task Standards for Children, if applicable, and distinguish between care that is typical for a child of the same age and care that exceeds age-appropriate expectations. Only supports that rise above normal developmental caregiving, and meet the definition of Extraordinary Care, may be authorized as CFC or waiver services.

LL. Annual CFC Service Soft Caps means annual utilization limits, expressed in hours per Person Centered Support Plan year. Annual CFC Service Soft Caps shall only be exceeded when approved through the CFC Direct Care Services Exception Process as described in Section 8.7607.A.

8.7503 Acupuncture

8.7503.A Acupuncture Eligibility

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

8.7503.B Acupuncture Definition

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

8.7503.C Acupuncture Inclusions

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

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

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

8.7503.D Acupuncture Exclusions and Limitations

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

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

8.7503.E Acupuncture Service Provider Agency Requirements

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

2. Acupuncture Provider Agencies shall:

a. Determine the appropriate modality, amount, scope, and duration of acupuncture within the established limits as described at Section 8.7503.D.2.

b. Recommend only services that are necessary and appropriate in a service plan.

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

8.7504 Adaptive Therapeutic Recreational Equipment and Fees

8.7504.A Adaptive Therapeutic Recreational Equipment and Fees Eligibility

1. Adaptive Therapeutic Recreational Equipment and Fees is a covered benefit available to Members enrolled in the following HCBS waivers:

   a. Children's Extensive Supports Waiver.

   b. Supported Living Services Waiver

8.7504.B Adaptive Therapeutic Recreational Equipment and Fees Definition

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

8.7504.C Adaptive Therapeutic Recreational Equipment and Fees Inclusions

1. Adaptive Therapeutic Recreational Equipment and Fees is authorized for Organized Health Care Delivery System (OHCDS).

2. Adaptive therapeutic recreational equipment may include an adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a Member with a Developmental Disability.

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

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

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

1. The following items are specifically excluded and not eligible for reimbursement:

    a. Entrance fees for:

        i. Zoos;

        ii. Museums;

        iii. Movie theaters, performance theaters, concerts, other entertainment venues; and

        iv. Professional and minor league sporting events.

    b. Outdoor play structures; and

    c. Batteries for recreational items.

8.7504.E Adaptive Therapeutic Recreational Equipment and Fees Reimbursement

1. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is $1,000.00 per support plan year.

8.7505 Adult Day Services

8.7505.A Adult Day Services Eligibility

1. Adult Day Services (ADS) is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Brain Injury Waiver

    b. Community Mental Health Services Waiver

    c. Complementary and Integrative Health Waiver

    d. Elderly, Blind, and Disabled Waiver

8.7505.B Adult Day Services Descriptions and Definitions

1. Adult Day Services (ADS) Centers are certified centers that provide Basic Adult Day Services and Specialized Adult Day Services to Members.

2. Adult Day Services (ADS) may be provided out of an Adult Day Services Center or through Non-Center-Based means including Telehealth.

3. Adult Day Services are provided on a regularly scheduled basis. Services must be delivered as specified in the Member’s Provider Care Plan, and promote

social, recreational, physical, and emotional well-being, and shall encompasses the supportive services needed to ensure the optimal wellness of the Member.

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

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

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

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

8. Specialized Adult Day Services (SADS) Center means a community-based entity providing Adult Day Services for Members with a primary diagnosis of dementia related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington’s Disease, Parkinson’s, or post-stroke Members, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have one of any of these diagnoses. Each diagnosis must be verified by a Licensed Medical Professional either directly or through Case Management Agency documentation, in accordance with Section 8.7505.E.9.

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

8.7505.C Adult Day Services Inclusions

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

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

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

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

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

4. Nutrition services including therapeutic diets and snacks in accordance with the Member's individual Provider Care Plan and hours of attendance. Nutrition services are not required during the delivery of Non-Center-Based ADS.

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

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

8.7505.D Specialized Adult Day Services

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

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

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

4. Adult Day Services Exclusions and Limitations

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

8.7505.E Adult Day Services Provider Agency Requirements

1. General

   a. Adult Day Services Provider Agencies shall be Medicaid certified by the Department in accordance with Section 8.7403.A. Proof of Medicaid Certification consists of an approved Provider Agreement by the Department and the Department's fiscal agent, and a recommendation for Certification from the Colorado Department of Public Health and Environment (CDPHE).

2. Environment

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

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

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

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

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

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

3. Food Safety Requirements

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

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

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

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

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

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

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

2) Any equipment or surfaces used in the preparation and service of food shall be washed, rinsed, and sanitized before use or at least every 4 hours of continual use. Dish detergent shall be labeled for its intended purpose. Sanitizer shall be approved for use as a no-rinse food contact sanitizer. Sanitizers shall be registered with the Environmental Protection Agency (EPA) and used in accordance with labeled instructions.

4. Medication Administration and Monitoring

a. Adult Day Service Provider Agencies shall comply with Medication Administration regulations in Section 8.7414.

5. Records and Information

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

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

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

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

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

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

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

6. Service Plan

a. The ADS Provider Agency shall document the following information in a care plan, which shall be used to direct the Member's care.

i. Medical Information:

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

2) Special dietary considerations or instructions;

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

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

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

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

ii. Provider Care Plan Planning Documentation:

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

2) Individual choices, including location and delivery method for ADS, preferences, and needs shall be incorporated into the goals and services outlined in a care plan;

3) All Member information and the service plan are considered Protected Health Information and shall be kept confidential; and

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

5) Any changes to the Person-Centered Support Plan must comply with Section 8.7001.B.4.

6) Any changes to the care plan must comply with Section 8.7410.

7) Documentation of whether the Member has executed an advance directive or other declaration regarding medical decisions.

7. Staff Requirements

a. In determining appropriate staffing levels, the Adult Day Services Provider Agency shall adjust staffing ratios based on the individual acuity and needs of the Members being served. At a minimum, staffing must be sufficient in number to provide the services described in the Provider Care Plan, considering the individual needs, level of assistance, and risks of accidents. A staff person may perform multiple functions, if those functions are consistent with the definition of Direct Care Worker, Section 8.7402.F. Staff counted in the staff-Member ratio are those who are trained and able to provide direct services to Members.

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

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

b. Staff shall provide:

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

ii. Activities that are planned to support the Person-Centered Support Plans or Provider Care Plan for the Members.

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

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

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

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

8. Director Qualifications

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

i. At least a bachelor's degree from an accredited college or university and a minimum of two years of social services or health

services experience and shall have demonstrated ability to perform all aspects of the position; or

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

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

9. Training Requirements

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

b. Direct Care Workers shall complete training prior to providing services.

10. Dementia Training Requirements

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

b. Definitions applicable to Dementia Training Requirements: In addition to those definitions set forth at Section 25.5-6-314, C.R.S., the following definitions apply to regulations in this Section 8.7505.E:

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

ii. “Dementia diseases and related disabilities” is a condition in which cognitive ability declines and is severe enough to interfere with an individual’s ability to perform everyday tasks. Dementia diseases and related disabilities include Alzheimer’s disease, mixed dementia, Lewy Body Dementia, vascular dementia, frontotemporal dementia, and other types of dementia.

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

iv. "Equivalent training" means any initial training provided by a Covered Facility that meets the requirements in Section 8.7505.E.10.c. If the Equivalent Training was provided more than 24 months prior to the date of hire as allowed in the exception found in Section 8.7505.E.10.d., the individual must document participation in both the Equivalent Training and all required continuing education subsequent to the initial training.

c. Initial training: Each Adult Day Services Provider Agency is responsible for ensuring that all Direct Care Workers are trained in dementia diseases and related disabilities.

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

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

1) Dementia diseases and related disabilities;

2) Person-centered care;

3) Care planning;

4) Activities of Daily Living; and

5) Dementia-related behaviors and communication.

iii. For Direct Care Workers already employed prior to October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after October 1, 2023, unless an exception, as described in Section 8.7505.E.10.d.i. applies.

iv. For Direct Care Workers hired or providing care on or after October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after the start of employment or the provision of direct-care services, unless an exception, as described in Section 8.7505.E.10.d.ii applies..

d. Exception to initial dementia training requirement

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

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

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

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

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

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

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

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

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

iii. Such exceptions shall not exempt a Direct Care Worker from the requirement for dementia training continuing education as described in Section 8.7504.E.10.e.

e. Dementia Training: Continuing Education

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

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

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

f. Minimum requirements for individuals conducting dementia training:

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

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

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

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

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

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

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

iv. Documentation of the satisfactory completion of an equivalent initial training program shall include the information required in this Section 8.7505.E.10.g.ii. and iii.

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

11. Written Policies

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

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

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

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

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

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

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

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

8.7505.F Adult Day Services Provider Agency Reimbursement Requirements

1. Claims for reimbursement for Adult Day Services provided to Members in the HCBS Elderly, Blind and Disabled (EBD), Community Mental Health Supports (CMHS), and the Complementary and Integrative Health (CIH) waivers shall be submitted in accordance with the current rate schedule:

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

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

ii. A Provider Agency may bill the maximum of 15-minute units for ADS in combination with no more than 1 unit of 3-5 hour ADS on the same day, only if services were rendered consecutively.

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

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

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

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

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

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

6. Adult Day Services are not covered when provided on the same date as HCBS residential services, unless the following criteria have been met:

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

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

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

d. Documentation from the Member's physician recommends Adult Day Services and describes how it will meet the Member's needs as described in subsection b, above.

8.7506 Alternative Care Facility

8.7506.A Alternative Care Facility Eligibility

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

    a. Community Mental Health Services Waiver

    b. Elderly, Blind, and Disabled Waiver

8.7506.B Alternative Care Facility Definitions

1. Alternative Care Facility defined at C.R.S. § 25.5-6-303(3), means an Assisted Living Residence , which has been licensed by the Colorado Department of Public Health and Environment (CDPHE) as an Assisted Living Residence and certified by the Department to provide Alternative Care Services to Medicaid Members.

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

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

8.7506.C Alternative Care Facility Inclusions

1. Member Eligibility

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

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

1) An assessment shall be conducted prior to admission, annually, whenever there is a significant change in physical, cognitive, or behavioral needs, or as requested by the Member. The annual assessment must be completed by the team described in Section 8.7506.C.1.a.i.

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

8.7506.D Alternative Care Facility Member Benefits

1. Alternative Care Services described at Section 8.7506.B.1.a are benefits to Members residing in an Alternative Care Facility .

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

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

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

8.7506.E Alternative Care Facility Member Rights

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

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

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

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

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

6. Alternative Care Facility Provider Agencies shall inform Members of the setting's policies and procedures for implementation of an individual's advance directives.

7. Alternative Care Facility Provider Agencies shall not require Medicaid Members to take part in performing household cleaning or maintenance tasks.

8.7506.F Alternative Care Facility Provider Agency Requirements

1. Alternative Care Facility Provider Agencies shall be licensed by the Colorado Department of Public Health and Environment as an Assisted Living Residence facility and obtain an Alternative Care Facility Certification prior to enrollment with the Department.

2. Member Engagement

a. In consultation with Members served, Alternative Care Facility Provider Agencies shall provide social and recreational engagement opportunities both within and outside the setting.

i. Opportunities for social and recreational engagement shall take into consideration the individual interests and wishes of the Members.

ii. In determining the types of opportunities and activities offered, the Provider Agencies shall consider the physical, social, and mental stimulation needs of the Members.

3. Member Leave

a. Alternative Care Facility Provider Agencies shall notify the Member's Case Manager of any Member planned or unplanned non-medical and/or programmatic leave of a duration greater than 24 hours.

b. The therapeutic and/or rehabilitative purpose of leave shall be documented in the Member's Provider Care Plan.

4. Provider Care Plan

a. The following information must be documented in the Member's Provider Care Plan:

i. Medical Information:

1) Medications the Member takes and how they are administered, with reference to the Medication Administration Record (MAR);

2) Special dietary needs, if any; and

3) Physician orders.

ii. Social and recreational engagement:

1) The Member's preferences and current relationships; and

2) Any recommended restrictions on social and/or recreational activities identified by a physician.

iii. Any other special health or behavioral management needs that support the Member's individual needs.

b. Additional Provider Care Plan Documentation:

i. Documentation from the admission process which demonstrates that the setting was selected by the Member;

ii. Identification of the Member's goals, choices, preferences, and needs and incorporation of these elements into the supports and services described in the Person-Centered Support Plan;

iii. Any modifications to the Member's rights, with the required supporting documentation; and

iv. Evidence the Member and/or their Guardian, or other Legally Authorized Representative has had the opportunity to participate in the development of the Provider Care Plan, as evidenced by the Member or other Legally Authorized Representatives' signature on the plan.

5. Environmental Standards

a. The Alternative Care Facility shall be an environment that supports individual comfort, independence, and preference, maintains a home-like quality and feel for Members at all times, and provides Members with unrestricted access to the Alternative Care Facility in accordance with the residency agreement or modifications as agreed to and documented in the Member's Provider Care Plan.

b. Alternative Care Facilities shall provide an outdoor area accessible to Members without staff assistance that is well maintained, facilitates community gatherings, and is appropriately equipped for the population served.

c. Alternative Care Facilities shall maintain a comfortable temperature throughout the Alternative Care Facility and Member rooms, sufficient to accommodate the use and needs of the Members, never to fall outside the range of 68 degrees to 76 degrees Fahrenheit.

d. The Alternative Care Facility shall develop and follow written policies and procedures to ensure the continuation of necessary care to all Members for at least 72 hours immediately following any emergency including, but not limited to, a long-term power failure.

e. The Alternative Care Facility Provider Agency shall display the monthly schedule of daily recreational and social engagement opportunities in a visible location so that it is always available to Members and visitors, and developed in accordance with 6 C.C.R. 1011-1, Chapter VII, Section 12.26, pertaining to Member Engagement.

i. Staff shall be responsible for ensuring that the daily schedule of recreational and social engagement opportunities is implemented and offered to all Members.

f. The Alternative Care Facility Provider Agency shall provide reading material in the common areas at all times, reflecting the interests, hobbies, and requests of the Members.

g. The Alternative Care Facility Provider Agency shall provide nutritious food and beverages that Members have access to at all times. Access to food and cooking of food shall be in accordance with 6 C.C.R. 1011-1, Chapter VII, Section 17.1-3. The access to food shall be provided in at least one of the following ways:

i. Access to the Alternative Care Facility kitchen.

ii. Access to an area separate from the Alternative Care Facility kitchen stocked with nutritious food and beverages.

iii. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the Member's bedroom.

iv. A safe, sanitary way to store food in the Member's room.

h. The Alternative Care Facility Provider Agency shall assess each Member's cooking capacity shall be assessed as part of the pre-admission process and updated in the Provider Care Plan as necessary.

6. Staffing Requirements

a. In determining appropriate staffing levels, the Alternative Care Facility Provider Agency shall adjust staffing ratios based on the individual acuity and needs of the Members in the Alternative Care Facility. At a minimum, staffing must be sufficient in number to provide the services described in the Provider Care Plan, considering the Member's needs, level of assistance, and risks of accidents. A staff person may have multiple functions, as long as they meet the definition of Direct Care Worker at Section 8.7402.F Staff counted in the staff-to-Member ratio are those who are trained and able to provide direct services to Members.

b. The Alternative Care Facility Provider Agency shall ensure that all staff and volunteer training be completed within the first 30 days of employment. Training shall include, but is not limited to, the training topics described in 6 C.C.R. 1011-1, Chapter VII, Section 7.9.

c. The Provider Agency shall ensure the Administrator and all staff meet the qualifications and employment standards set forth in 6 C.C.R. 1011-1, Chapter VII, Section 7.4.

8.7506.G Alternative Care Facility Standards for Secured Environment

1. Alternative Care Facility Provider Agencies providing a secured environment may be licensed for a maximum of 30 secured beds.

    a. A waiver may be granted by the Department when adequate documentation of the need for additional beds has been proven and the number of beds would not jeopardize the health, safety and quality of care of Members.

2. The Alternative Care Facility shall establish an environment that promotes independence and minimizes agitation and unsafe wandering through the use of visual cues and signs.

3. Provide a secured outdoor area accessible without staff assistance, which shall be level, well maintained, and appropriately equipped for the population served.

8.7506.H Appropriateness of Medicaid Participant Placement

1. Alternative Care Facilities must comply with 6 C.C.R. 1011-1 Chapter 7, Part 11 when admitting a Member or providing a 30 days' notice of discharge.

8.7506.I Alternate Care Facility Provider Agency Reimbursement Requirements

1. Room and board shall not be a benefit of Alternative Care Facility services.

2. Alternative Care Facility services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.

    a. Alternative Care Facility services are subject to Post Eligibility Treatment of Income (PETI), as outlined in Section 8.7202.BB.

3. Non-Medical/Programmatic Leave Reimbursement

    a. The Alternative Care Facility may receive reimbursement for a maximum of 42 days in a calendar year for Non-Medical/Programmatic Leave Days combined.

    b. The Alternative Care Facility shall not be reimbursed for services during Leave Days if the Member is receiving Medicaid services over 24 hours in another approved Medicaid Facility, such as a nursing facility or hospital.

8.7507 Assistive Technology

8.7507.A Assistive Technology Eligibility

1. Assistive Technology is a covered service available to Members enrolled in one of the following HCBS waivers:

    a. Brain Injury Waiver

b. Children's Extensive Supports Waiver

c. Supported Living Services Waiver

8.7507.B Assistive Technology Definitions

1. Assistive Technology Device means an item, piece of equipment, or product system, including tablets, software, and phone applications, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of Members.

2. Assistive Technology Service means a service that directly assists a Member in the selection, acquisition, or use of an assistive technology device.

8.7507.C Assistive Technology Inclusions

1. Assistive Technology is authorized for Organized Health Care Delivery System (OHCDS).

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

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

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

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

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

   e. Training or technical assistance for the Member, or where appropriate, the Family Members, Guardians, caregivers, advocates, or Legally Authorized Representatives of the Member.

   f. Warranties, repairs, or maintenance on assistive technology devices purchased through the waiver.

   g. Adaptations to computers, or computer software related to the Member's identified needs in their Person-Centered Support Plan.

3. HCBS Brain Injury (BI) Waiver

a. For Members enrolled in the HCBS-BI Waiver, the following are covered Assistive Technology benefits:

i. Specialized medical equipment and supplies including devices controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform Activities of Daily Living, or to perceive, control, or communicate with the environment in which they live.

ii. Assistive devices that augment an individual's ability to function at a higher level of independence.

iii. Assistive devices that enable the individual to secure help in the event of an emergency or are used to provide reminders to the individual of medical appointments, treatments, or medication schedules.

iv. Assistive devices to augment cognitive processes, “cognitive-orthotics” or memory prostheses. Examples of cognitive orthotic devices include informational databases, spell checkers, text outlining programs, timing devices, security systems, car finders, sounding devices, cueing watches, electronic medication monitors, and memory communication devices.

v. Training or technical assistance for the Member, or where appropriate, the Family Members, Guardians, caregivers, advocates, or Legally Authorized Representatives of the Member.

vi. Warranties, repairs, or maintenance on assistive technology devices purchased through the waiver.

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

8.7507.D Assistive Technology Exclusions and Limitations

1. Assistive technology devices and services are only available to meet needs identified through the Person-Centered Support Plan. They shall be the most cost effective and efficient means to meet the identified need and cannot be available through the Medicaid state plan, other HCBS Waiver Services, or third-party resources.

2. Items which are not of direct medical or remedial benefit to the Member are excluded

3. HCBS Supported Living Services (SLS) Waiver, Children’s Extensive (CES) Waiver:

a. When the expected cost exceeds $2,500 per device, the Case Manager shall obtain and maintain three estimates in the case record and the most cost-effective option shall be selected. When it is not possible to obtain three estimates, documentation shall be maintained in the case record the reason for less than three estimates.

b. The following devices and services are specifically excluded under HCBS waivers and not eligible for reimbursement:

i. Purchase, training, or maintenance of service animals,

ii. Computers or cell phones unless prior authorized according to procedure.

iii. Training or adaptation directly related to a school or home educational goal or curriculum for members under 21 years of age.

iv. Internet or broadband access.

v. In-home installed video monitoring equipment.

vi. Medication reminders.

vii. Items considered as typical toys for children.

viii. Items or devices that are experimental.

ix. Items or devices that are used for typical daily activities and are not used to increase, maintain, or improve the functional capabilities of Members.

8.7507.E Assistive Technology Reimbursement Requirements

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

a. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver without an exception granted by the Department.

b. Costs that exceed this limitation may be approved by the Department for devices to ensure the health and safety of the Member or that enable the Member to function with greater independence in the home or if it decreases the need for paid assistance in another waiver service on a long-term basis.

c. Requests for an exception shall be prior authorized within 30 days of the request in accordance with the Department's procedures.

2. HCBS Brain Injury (BI) Waiver:

    a. Reimbursement for assistive devices will be on a per unit basis. If assistive devices are to be used primarily in a vocational application, devices should be funded through the Division of Vocational Rehabilitation with secondary funding from Medicaid

8.7508 Behavioral Programming/Behavioral Management and Education

8.7508.A Behavioral Programming/Behavioral Management and Education Eligibility

1. Behavioral Programming/Behavioral Management and Education is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.7508.B Behavioral Programming/Behavioral Management and Education Definition

1. Behavioral programming and education means individually developed interventions designed to decrease/control the Member's severe maladaptive behaviors which, if not modified or prevented, will interfere with the Member's ability to remain integrated in the community.

8.7508.C Behavioral Programming/Behavioral Management and Education Inclusions

1. Programs should consist of a comprehensive Assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of Family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the Member's environment.

2. Behavioral programs may be provided in the community, or in the Member's residence unless the residence is a Transitional Living Program which provides behavioral intervention as a treatment component.

3. All behavioral programming must be documented in the Member’s Provider Care Plan and may not exceed 30 units of service. The Department may authorize additional units based on needs identified in the Member’s Person-Centered Support Plan or Provider Care Plan.

8.7508.D Behavioral Programming/Behavioral Management and Education Provider Agency Requirements

1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a healthcare professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist,

Speech Language Pathologist, Registered Nurse or Master's level Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of behavioral management concepts.

2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with Brain Injury if their work experience does not include at least one year of the same.

8.7508.E Behavioral Programming/Behavioral Management and Education Reimbursement

1. The Case Manager must document the behavioral programming service on the Member's Person-Centered Support Plan and include the number of service units on the Member's Prior Authorization Request (PAR).

2. Behavioral programming services will be reimbursed on an hourly basis as established by the Department.

8.7509 Behavioral Therapies

8.7509.A Behavioral Therapies Eligibility

1. Behavioral Therapies are a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a. Developmental Disabilities Waiver

   b. Supported Living Services Waiver

   c. Brain Injury Waiver

8.7509.B Behavioral Therapies Definition

1. Behavioral Therapies mean services related to the Member's intellectual or Developmental Disability that assist a Member to acquire or maintain appropriate interactions with others.

8.7509.C Behavioral Therapies Inclusions

1. Behavioral Therapies shall address specific challenging behaviors of the Member and identify specific criteria for remediation of the behaviors.

2. A Member with a co-occurring diagnosis of an intellectual or Developmental Disability and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication

but with coordination by the behavioral services professional to obtain the best outcome for the Member.

3. Behavioral Therapies include:

   a. Behavioral consultations and recommendations for behavioral interventions and development of behavioral support care plans that are related to the Member's Developmental Disability and are necessary for the Member to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management.

   b. Intervention strategies related to an identified challenging behavioral need of the Member. Specific goals and procedures for the behavioral service shall be established.

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

   d. Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:

      i. Is related to the Developmental Disability in order for the Member to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

      ii. Positively impacts the Member's behavior or functioning, and

      iii. May include cognitive behavior therapy, systematic desensitization, anger management, biofeedback, and relaxation therapy.

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

      i. Delivered under the supervision and oversight of a behavioral consultant.

      ii. Inclusive of acute, short-term interventions at the time of enrollment from an institutional setting, or

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

8.7509.D Behavioral Therapies Exclusions and Limitations

1. Services covered as Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or a covered mental health diagnosis in the Medicaid State

Plan, covered by a third-party source or available from a natural support are excluded and shall not be reimbursed.

2. Behavioral consultation services are limited to 80 units per support plan year. One unit is equal to 15 minutes of service.

3. Behavioral plan Assessment services are limited to 40 units and one assessment per support plan year. One unit is equal to 15 minutes of service.

4. Behavioral line services are limited to 960 units per support plan year. One unit is equal to 15 minutes of service.

5. Counseling services are limited to 208 units per support plan year. One unit is equal to 15 minutes of service.

6. Services for the sole purpose of training basic life skills, such as Activities of Daily Living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

8.7509.E Behavioral Therapies Provider Agency Requirements

1. Behavioral Therapies consultants shall meet one of the following minimum requirements:

   a. Shall have a Master's degree or higher in behavioral, social, or health sciences or education and be nationally certified as a “Board Certified Behavior Analyst” (BCBA), or certified by a similar, nationally-recognized organization. Shall have at least 2 years of directly-supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practices for and research on effectiveness for people with intellectual and developmental disabilities; or

   b. Shall have a Baccalaureate degree or higher in behavioral, social, or health sciences or education and

      i. Be certified as a “Board Certified Assistant Behavior Analyst” (BCABA) or

      ii. Be enrolled in a BCABA or BCBA certification program or have completed a Positive Behavior Supports training program and be working under the supervision of a certified or licensed Behavioral Services Provider.

2.. Counselors shall meet one of the following minimum requirements:

a. Shall hold the appropriate license or certification for the provider's discipline according to state or federal law as a Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, Licensed Clinical Psychologist, or BCBA, and must demonstrate or document a minimum of two years' experience in providing counseling to individuals with intellectual and developmental disabilities; or

b. Have a Baccalaureate degree or higher in behavioral, social, or health science or education and work under the supervision of a licensed or certified professional as set forth in Section 8.7509.E.1.

3. Behavioral Plan Assessor shall meet one of the following minimum qualifications:

a. Shall have a Master's degree or higher in behavioral, social, or health science or education and be nationally certified as a BCBA or certified by a similar, nationally-recognized organization. Shall have at least 2 years of directly-supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practices for and research on effectiveness for people with intellectual and developmental disabilities; or

b. Shall have a Baccalaureate degree or higher in behavioral, social, or health science or education and be

i. certified as a "Board Certified Associate Behavior Analyst" (BCABA), or

ii. be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and working under the supervision of a certified or licensed Behavioral Services provider.

4. Behavioral Line Staff shall meet the following minimum requirements:

a. Must be at least 18 years of age, have graduated from high school or earned a high school equivalency degree, and have a minimum of 24 hours training inclusive of practical experience in the implementation of positive behavioral supports and/or applied behavioral analysis and that is consistent with best practices for and research on effectiveness for people with intellectual and developmental disabilities.

b. Must work under the direction of a Behavioral Consultant.

8.7510 Benefits Planning Service

8.7510.A Benefits Planning Service Eligibility

1. Benefits Planning Service is available to Members enrolled in one of the following HCBS waivers:

    a. Developmental Disabilities Waiver

    b. Supported Living Services Waiver

8.7510.B Benefits Planning Service Definition

1. Benefits Planning means analysis and guidance provided to a Member and their family/support network to improve their understanding of the potential impact of employment-related income on the Member's public benefits. Public benefits include, but are not limited to Social Security, Medicaid, Medicare, food/nutrition programs, housing assistance, and other federal, state, and local benefits. Benefits Planning gives the Member an opportunity to make an informed choice regarding employment opportunities or career advancement.

8.7510.C Benefits Planning Service Inclusion

1. Benefits Planning is available regardless of employment history or lack thereof and may be accessed throughout the phases of a Member's career such as: when considering employment, changing jobs, or for career advancement/exploration.

2. Certified Benefits Planners support Members by providing any of these core activities:

    a. Intensive individualized benefits counseling;

    b. Benefits verification;

    c. Benefit summary & analysis;

    d. Identifying applicable work incentives, and if needed, developing a work incentive plan for the Member and team;

3. In addition to the core activities, Benefits Planning may also be utilized to:

    a. Conduct an informational meeting with the Member, alone or with their support network.

    b. Assist with evaluating job offers, promotional opportunities (increase in hours/wage), or other job changes that the Member is considering which change income levels; and outlining the impact that change may have on public benefits.

c. Provide information on Waiver Benefits (including Buy-In options), federal/state/local programs, and other resources that may support the Member in maintaining benefits while pursuing employment.

d. Assist with referrals and connecting the Member with identified resources, as needed, and coordinating with the Member, Case Manager, family, and other team Members to promote accessing services/resources that will advance the Member's desired employment goals.

e. Navigate complicated benefit scenarios and offer problem-solving strategies, so the Member may begin or continue working while maintaining eligibility for needed services.

f. Offer suggestions to the Member and their family/support network regarding how to create and maintain a recordkeeping structure and reporting strategy related to benefit eligibility and requirements.

1) If the Member needs assistance with the collection and submission of income statements and/or documentation related to the Social Security Administration (SSA), or other benefits managing organizations, and the Member does not have other supports to do so, the Benefits Planner may assist on a temporary basis.

g. Assist in accessing federal/state/local resources, evaluating the potential impact on benefits due to changes in income, and if there is a negative impact identified, explore alternatives to meet existing needs, all in collaboration with the Member's Case Manager and support team.

8.75010.D Benefits Planning Service Exclusions and Limitations

1. Benefits Planning shall not take the place of, nor shall it duplicate services received through the Division of Vocational Rehabilitation.

2. Benefits Planning services are limited to 40 units per support plan year. One unit is equal to 15 minutes of service.

8.75010.E Benefits Planning Service Provider Agency Requirements

1. Benefits Planning may be provided only by Certified Benefits Planners. A Certified Benefits Planner holds at least one of the following credentials:

a. Community Work Incentives Coordinator (CWIC);

b. Community Partner Work Incentives Counselor (CPWIC);

c. Credentialed Work Incentives Practitioner (WIP-CTM).

2. Documentation of the Benefits Planner's Certification and additional trainings shall be maintained and provided upon request by a surveyor or the Department.

3. Certified Benefits Planners must obtain and sustain a working knowledge of Colorado's Medicaid Waiver system as well as federal, state, and local benefits.

4. The Benefits Planning provider must maintain records which reflect the Benefits Planning activities that were completed for the Member, including copies of any reports provided to the Member.

5. If the Certified Benefits Planner encounters a benefit situation that is beyond their expertise, consultation with technical assistance liaisons is expected.

8.7511 Bereavement Counseling

8.7511.A Bereavement Counseling Eligibility

1. Bereavement Counseling is a covered benefit available to Members and/or Family Members enrolled in the HCBS Children with Complex Health Needs (CwCHN) Waiver..

8.7511.B Bereavement Counseling Definition

1. Bereavement Counseling means counseling provided to the Member and/or Family Members to guide and help them cope with the Member's illness and the related stress that accompanies the continuous, daily care required by a child with a complex or life-threatening condition.

8.7511.C Bereavement Counseling Exclusions and Limitations

1. Bereavement Counseling shall be a benefit only if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or from other sources.

8.7511.D Bereavement Counseling Provider Agency Requirements

1. Bereavement Counseling shall be provided only by individuals licensed or certified in at least one of the following:

    a. Licensed Clinical Social Worker (LCSW)

    b. Licensed Professional Counselor (LPC)

    c. Licensed Social Worker (LSW)

    d. Licensed Independent Social Worker (LISW)

    e. Licensed Psychologist; or

f. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice agency.

2. Providers shall be licensed and in good standing with their specific specialty practice act or with current state licensure statutes and regulations.

3. Each individual providing Bereavement Counseling shall enroll as a Medicaid provider or be employed by an enrolled Medicaid home health or hospice provider agency.

8.7511.E Bereavement Counseling Reimbursement

1. Bereavement Counseling may be initiated and reimbursed while the Member is on the CwCHN waiver but may continue for one year following the death of the Member.

8.7512 Child and Youth Mentorship

8.7512.A Child and Youth Mentorship Eligibility

1. Child and Youth Mentorship is a covered benefit available to Members enrolled in the HCBS Children's Habilitation Residential Program Waiver.

8.7512.B Child and Youth Mentorship Definition

1. Child and Youth Mentorship means the implementation of therapeutic and/or behavioral service and support plans, building life skills, providing guidance to the child or youth with self-care, learning self-advocacy, and Protective Oversight as defined at Section 8.7506.B.2.

8.7512.C Child and Youth Mentorship Inclusions

1. This service may be utilized in maintaining stabilization, preventing Crisis situations, and/or de-escalation of a Crisis.

2. Service may be provided in the Member’s home or community as determined by the Wraparound Plan.

3. Child and Youth Mentorship may be provided individually, or in conjunction with the Wraparound Service, defined at Section 8.7557.

8.7512D Child and Youth Mentorship Provider Agency Requirements

1. Individuals providing Child and Youth Mentorship must meet the following criteria:

a. Complete at least 40 hours of training in Crisis Prevention, De-escalation, and Intervention that must encompass all of the following:

i. Trauma informed care.

ii. Youth mental health first aid.

iii. Positive Behavior Supports, behavior intervention, and de-escalation techniques.

iv. Cultural competency.

v. Family systems and Family engagement.

vi. Child and adolescent development.

vii. Mental health topics and services.

viii. Substance abuse topics and services.

ix. Psychotropic medications.

x. Prevention, detection, and reporting of mistreatment. abuse, neglect, and exploitation.

xi. Intellectual and Developmental Disabilities.

xii. Child/youth specific training.

b. Complete annual refresher courses on the above training topics.

8.7513 Chiropractic

8.7513.A Chiropractic Eligibility

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

8.7513.B Chiropractic Definition

1. Chiropractic means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting and/or improving alignment, neurological function, and other musculoskeletal problems. During a chiropractic treatment, nutrition, exercise, and rehabilitative therapies may be recommended in support of the adjustment.

8.7513.C Chiropractic Inclusions

1. Chiropractic may be utilized to treat conditions or symptoms related to the Member's qualifying condition and Inability to Independently Ambulate.

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

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

8.7513.D Chiropractic Exclusions and Limitations

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

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

8.7513.E Chiropractic Service Provider Agency Requirements

1. Chiropractors shall be licensed by the State Board of Chiropractic pursuant to § 12-215-101 et seq (C.R.S.) and have at least one year experience practicing Chiropractic at a rate of 520 hours per year; OR one year of experience working with individuals with paralysis or other long term physical disabilities.

2. Chiropractic Provider Agencies shall:

    a. Determine the appropriate modality, amount, scope, and duration of chiropractic service within the established limits described at Section 8.7513.D.2.

    b. Recommend only services that are necessary and appropriate in a care plan.

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

8.7514 Community Connector Services

8.7514.A Community Connector Services Eligibility

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

    a. Children's Extensive Support Waiver

b. Children's Habilitation Residential Program Waiver

8.7514.B Community Connector Services Definition

1. Community Connector services shall be delivered on a one-to-one basis exclusively to children with an assessed exceptional or extraordinary need whose need for community engagement support substantially exceeds age-typical Parental or Legal Guardian of a Minor Responsibilities, as defined by Section 8.7502.KK, and cannot be met solely through the age-typical actions or involvement of the parent or legal guardian.

2. Community Connector services shall support the Member's active and consistent engagement, meaningful participation, and contribution to community life by facilitating interaction with community members who are not paid supports, family, or known providers/caregivers, promoting integration into community settings available to the general public, and supporting the use of natural community resources. Community Connector services shall not supplant, replace, or duplicate supports that are Parental or Legal Guardian of a Minor Responsibilities, as defined by Section 8.7502.KK. This benefit shall not be available to children without an assessed age-appropriate extraordinary need, using the assessment in Section 8.400-499, Appendix A, as community engagement, activities, and skill development that fall within typical Parental or Legal Guardian of a Minor Responsibility are not covered under this service.

8.7514.C Community Connector Services Inclusions

1. Community Connector services shall be authorized only for Members who demonstrate an assessed age-appropriate extraordinary need, using the assessment in Section 8.400-499, Appendix A, that substantially exceeds age-appropriate and ordinarily expected Parental or Legal Guardian of a Minor Responsibilities, as defined in Section 8.7502.KK, and cannot be solely met through the age-typical actions or involvement of the Legally Responsible Person. Authorization shall be limited to circumstances in which the service is necessary to enable the Member to access and engage in community life with the general public.

2. Community Connector services shall support the development and maintenance of relationships with community members through inclusive, public, community-based activities. Activities shall be used as learning environments to build natural supports and community connections with individuals who are not paid supports, Family Members, providers or caregivers and to support the Member's increasing independence navigating and participating in broader community settings.

3. Community Connector services shall focus on developing and strengthening skills that promote the Member's increased independence in community settings, including the ability to actively and consistently participate for the majority of the

activity duration in activities that require meaningful engagement and are reasonably expected to develop or strengthen skills related to community engagement and independence. Skill development shall be directly related to the Member's assessed extraordinary need and documented goals.

4. Community Connector services shall be delivered exclusively on a one-to-one basis and are limited to supports necessary to enable the Member to access and engage in community life beyond age-typical. Parental or Legal Guardian of a Minor Responsibility.

5. Community Connector services shall be delivered in accordance with a Person-Centered Support Plan that identifies targeted skills and behaviors, includes measurable and time-limited goals, and clearly outlines the strategies, supports, and methods to address the Member's extraordinary community engagement needs.

6. Community Connector services shall be delivered in coordination with all other appropriate waiver and non-waiver services, as applicable, to ensure a comprehensive and non-duplicative approach to meeting the Member's Extraordinary Care needs.

8.7514.D Community Connector Services Exclusions and Limitations

1. Community Connector services are limited to 1,040 units per Person-Centered Support Plan (PCSP) year. This unit limit applies to Community Connector services provided by a Legally Responsible Person(s), another service provider, or any combination thereof.

    a. Community Connector Service Limit Exception Request

        i. Community Connector Service Limit Exception Request means the required process for requesting and authorizing service units above 1,040 units per PCSP year. Case Managers must follow the guidelines outlined at Section 8.7514.D.1.a.ii. and all additional operational guidance from the Department. The Department must follow the requirements outlined at Section 8.7514.D.1.a.iii.

        ii. Community Connector Service Limit Exception Request Case Manager Responsibilities

            1) Case Managers are responsible for submitting a Community Connector Service Limit Exception Request to the Department at least 30 calendar days prior to the service start date only if an assessed, age-appropriate exceptional need is present, all proposed activities meet applicable requirements, and the time reasonably necessary to complete those activities exceeds the 1,040-unit limit. The

Case Manager makes the final determination on submitting a Community Connector Service Limit Exception Request.

2) In each Community Connector Service Limit Exception Request, the Case Manager must include Member-specific documentation, including assessment findings and service plan details outlining other authorized services, that demonstrate service appropriateness and compliance with applicable policy.

3) In each Community Connector Service Limit Exception Request, the Case Manager must clearly describe the Member's needs, the reason the annual 1,040 unit limit is insufficient, and how the requested exception supports the Member's health, safety, and community-based living.

4) Case Managers are responsible for responding to requests for additional information within 7 calendar days. If additional information is not provided to the Department, the Department will issue an outcome based on the information that was initially provided.

5) Case Managers shall ensure compliance with all Member noticing requirements and issue a Notice of Action for any adverse action, as described in Section 8.7202.R., taken as a result of the Community Connector unit limit or the Community Connector Service Limit Exception Request.

6) Case Managers must involve Members in the Community Connector Service Limit Exception Request by reviewing materials with the Member prior to submitting a Community Connector Service Limit Exception Request and providing copies of submitted information, requests for additional information, and Community Connector Service Limit Exception Request outcomes at the Member's request.

iii. Community Connector Service Limit Exception Request Department Responsibilities

1) The Department will provide an initial response to the Case Manager regarding the Community Connector Service Limit Exception Request within 14 calendar days.

a) If additional information is needed for the Department to process the Community Connector Service Limit Exception Request, a request for additional information will be provided to the submitting Case Manager. If additional information is not provided to

the Department, the Department will issue an outcome based on the information that was initially provided.

2) The Department will review Community Connector Service Limit Exception Requests for:

   a) Whether the service units requested are duplicative and/or meet the definition of Extraordinary Care;

   b) The reason the annual 1,040 units are insufficient based on the Members assessed need and the previously approved units;

   c) How the Community Connector Service Limit Exception Request maintains the Member's health and safety and promotes sustainable community-based living; and

   d) Age-appropriateness and for duplication of Parental or Legal Guardian of a Minor Responsibilities.

3) The Department shall approve additional hours on a case-by-case basis when a demonstrated need is documented and justified by the Member's Case Manager and sufficiently meets the review criteria outlined at Section 8.7514.D.1.iii.

4) The Department shall issue a determination letter for each Community Connector Service Limit Exception Request unless the Community Connector Service Limit Exception Request is withdrawn by the Case Manager. Each determination letter shall include:

   a) The type of exception that was requested;

   b) The amount of units requested by the Case Manager;

   c) The approved, partially approved, or denied service units;

   d) A summary of the documentation reviewed, including the PCSP and supporting justification; and

   e) The regulatory citation(s) to support the decision.

5) The Community Connector Service Limit Exception Request process shall be implemented in a uniform manner applied

equally to Members statewide, but outcomes shall be based on individual assessed needs and circumstances.

2. Units shall be authorized only for activities directly related to the Member's assessed age-appropriate extraordinary need, using the assessment in Section 8.400-499, Appendix A, community engagement needs, and shall reflect the reasonable amount of time necessary to support those activities on a weekly basis.

3. Telehealth Community Connector services shall not be provided by the Member's Legally Responsible Person(s).

4. The following activities are excluded from Community Connector services:

    a. Activities that involve only brief, incidental, or minimal interaction with community members who are not paid supports or Family Member(s), or that do not otherwise involve meaningful engagement with others in community settings the majority of the activity.

    b. Activities that fall within age-appropriate and ordinarily expected Parental or Legal Guardian of a Minor Responsibilities, as defined in Section 8.7502.KK, or that would otherwise duplicate, replace, or supplant such responsibilities.

    c. Specialized or segregated activities that only take place in the community but do not promote inclusive participation or integration into the broader community.

    d. Admission, registration, or membership fees, and food or beverage costs, which are not reimbursable under this service.

    e. Services or supports provided through, or otherwise available through, the educational system, including school-based or home school-based services, or that would otherwise duplicate, replace, or supplant such services.

5. The paid support providing Community Connector services shall not be responsible for the supervision, care, or support of any other child(ren) or individual during any time for which Community Connector services are billed.

8.7515 Consumer Directed Attendant Support Services (CDASS)

8.7515A CDASS Eligibility

1. CDASS is a covered benefit available to Members enrolled in CFC.

8.7515.B CDASS Definitions

1. Adaptive Equipment is as defined at 8.7502.

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

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

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

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

6. Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that empowers Members to direct their care and services to assist them in accomplishing Activities of Daily Living when included as a CFC Benefit. CDASS benefits may include assistance with health maintenance, personal care, and homemaker activities.

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

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

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

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

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

12. Intentionally omitted

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

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

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

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

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

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

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

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

8.7515.C CDASS Member Eligibility

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

    a. Choose the CDASS delivery option.

    b. Be enrolled in CFC.

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

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

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

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

        i. Member orientation obligations

            1) Members and ARs who have completed orientation through the Training and Support Contractor in the past two years or utilized CDASS in the previous six months may receive a modified orientation to begin or resume CDASS. A Member who was terminated from CDASS due to a Medicaid Financial Eligibility denial that has been resolved may

resume CDASS without attending orientation if they received CDASS in the previous six months.

8.7515.D CDASS Inclusions and Covered Services

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

2. Services include:

   a. Homemaker services as described at Section 8.7527.

   b. Personal Care services as described at Section 8.7538.

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

8.7515.E CDASS Exclusions and Limitations

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

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

   b. Following the death of the Member.

2. The Attendant shall not be reimbursed for performing tasks when the Member is concurrently receiving a waiver service or CFC service for which a provider is required to perform the same task as part of a billed service.

3. Companionship is not a covered CDASS service.

4. Billing for travel time to and from the Member's home at the beginning and end of the visit is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Employers must follow all Department of Labor and Employment guidelines on time worked.

5. All CDASS tasks must meet Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older. If additional hours are needed beyond the Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults, Case Managers shall follow the CFC Direct Care Services Exception Request process described in Section 8.7607.A.

6. Authorization of CDASS tasks must be limited to services that exceed those considered part of Parental or Legal Guardian of a Minor Responsibility as defined at Section 8.7502.KK.

7. This service is subject to the following Annual CFC Service Soft Caps: Members shall not be authorized for more than 4,750 hours per PCSP of Health Maintenance Activities, 2,500 hours per PCSP of Personal Care, and/or 1,125 hours per PCSP of Homemaker services. Case Managers may request additional hours through the Department prescribed exception process outlined in Section 8.7607.A.

8. Members may receive up to 364 hours of Homemaker services annually from a Legally Responsible Person. Additional hours may be authorized when services are provided by a non-Legally Responsible Person.

9. Attendants must adhere to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

8.7515.F CDASS Attendant Support Management Plan

1. The Member/Authorized Representative (AR) shall develop a written Attendant Support Management Plan (ASMP) after completion of orientation but prior to the start date of services, which shall be reviewed by the Training and Support Contractor and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date to the Financial Management Services (FMS) Contractor. The Attendant Support Management Plan shall be completed following initial orientation and mandatory coaching and shall be modified when there is a change in the Member's needs. The plan shall describe the Member's:

    a. Attendant support needs;

    b. Plans for locating and hiring Attendants;

    c. Plans for handling emergencies;

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

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

    f. Designation of an AR, if applicable; and

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

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

most recently approved ASMP shall remain in effect while the review is in process.

8.7515.G CDASS Member/AR Responsibilities

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

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

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

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

   d. Determine the required qualifications for Attendants.

   e. Recruit, hire and manage Attendants.

   f. Complete employment reference checks on Attendants.

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

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

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

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

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

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

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

   n. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation. Services that exceed the Member's

monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the Member or AR for reimbursement through the FMS Contractor unless prior approval is obtained from the Department or its designee.

o. Authorize Attendant to perform services allowed through CDASS.

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

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

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

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

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

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

v. Select an FMS Contractor upon enrollment into CDASS.

2. Member/AR responsibilities for Verification:

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

3. Members utilizing CDASS have the following rights:

a. To receive training on managing CDASS.

b. To receive program materials in accessible format.

c. To receive advance Notification of changes to CDASS.

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

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

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

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

8.7515.H CDASS Authorized Representatives (AR)

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

   a. Is at least eighteen years of age;

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

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

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

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

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

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

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

8.7515.I CDASS Attendants

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

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

   b. Attendants may not be reimbursed for more than sixteen (16) hours of care per day for one or more members collectively.

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

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

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

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

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

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

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

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

10. Attendants must adhere to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

8.7515.J CDASS Financial Management Services (FMS)

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

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

    b. Conduct payroll functions, including withholding employment-related taxes such as workers' compensation insurance, unemployment benefits,

withholding of all federal and state taxes, and compliance with federal and state laws regarding overtime pay and minimum wage.

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

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

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

f. Track and report utilization of Member Allocations.

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

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

i. Enforce Weekly Caregiver Limit and Per Day Hourly Caregiver Limit as outlined in Section 8.7419, and accurately process and retain documentation that supports any pending or approved exceptions to those limits.

2. In addition to the requirements set forth at Section 8.7515.J.1, the FMS Contractor operating under the Fiscal/Employer Agent (F/EA) model shall be responsible for obtaining designation as a Fiscal/Employer Agent in accordance with Section 3504 of the Internal Revenue Code, 26 U.S.C § 2504 (2024).

8.7515.K CDASS Selection of Financial Management Services (FMS) Contractor

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

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

8.7515.L CDASS Start of Services

1. The CDASS start date shall not occur until all of the requirements contained in Sections 8.7515.C, 8.7515.F, 8.7515.G, 8.7515.H have been met.

2. The Case Manager shall approve the Attendant Support Management Plan (ASMP), establish a service period, submit a Prior Authorization Request (PAR)

and receive a Prior Authorization Request (PAR) approval before a Member is given a start date and may begin CDASS.

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

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

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

8.7515.M CDASS Service Substitution

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.7515.O CDASS Immediate Involuntary Termination

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

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

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

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

the Department has determined that the Training and Support Contractor has made attempts to assist the Member/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

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

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

f. Instances of proven fraud, abuse, and/or theft in connection with the Colorado Medical Assistance program.

g. Member/AR fails to complete mandatory coaching, appoint an AR, or remediate CDASS management per Section 8.7515.N.1.

h. Member/AR demonstrates a consistent pattern of non-compliance with Electronic Visit Verification (EVV) requirements determined by the EVV CDASS protocol.

i. Members experiencing FMS EVV systems issues must notify the FMS Contractor and/or Department of the issue within five (5) business days. In the event of a confirmed FMS EVV system outage or failure impacting EVV submissions, the Department will not impose strikes or pursue termination, as appropriate, as outlined in the EVV Compliance protocol.

8.7515.P Ending the CDASS Delivery Option

1. If a Member chooses to use an alternate care option or is terminated involuntarily, the Member will be terminated from CDASS when the Case Manager has secured an adequate alternative to CDASS in the community.

2. In the event of discontinuation of or termination from CDASS, the Case Manager shall:

   a. Complete the Long Term Care Notice of Action (LTC-803) and provide the Member or Authorized Representative (AR) with the reasons for termination, information about the Member's rights to fair hearing, and appeal procedures. Once notice has been given for termination, the Member or AR may contact the Case Manager for assistance in obtaining other home care services or additional benefits, if needed.

b. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS and begin alternate care services. Exceptions may be made to increase or decrease the thirty (30) day advance notice requirement when the Department has documented that there is danger to the Member. The Case Manager shall notify the FMS Contractor of the date on which the Member is being terminated from CDASS.

3. Members who are involuntarily terminated pursuant to Sections 8.7515.O.1.b, 8.7515.O.1.d, 8.7515.O.1.e, 8.7515.O.1.f, and 8.7515.O.1.g may not be re-enrolled in CDASS as a service delivery option.

4. Members who are involuntary terminated pursuant to Section 8.7515.O.1.a are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at 8.7515.C.1.e. The Member or AR must have successfully completed CDASS orientation prior to enrollment in CDASS.

5. Members who are involuntary terminated pursuant to 8.7515.O.1.c are eligible for enrollment in CDASS with the appointment of an AR. The Member must meet all CDASS eligibility requirements with the AR completing CDASS orientation prior to enrollment in CDASS.

6. Members who are involuntarily terminated pursuant to 8.7515.O.1.h are eligible for enrollment in CDASS 365 days from the date of termination. The Member must meet all eligibility requirements and complete CDASS orientation prior to enrollment in CDASS.

8.7515.Q CDASS Case Management Functions

1. The Case Manager shall review and approve the Attendant Support Management Plan (ASMP) completed by the Member/Authorized Representative (AR). The Case Manager shall notify the Member/AR of ASMP approval and establish a service period and Allocation.

2. If the Case Manager determines that the ASMP is inadequate to meet the Member's CDASS needs, the Case Manager shall work with the Member/AR to complete a fully developed ASMP.

3. The Case Manager shall calculate the Allocation for each Member who chooses CDASS as follows:

   a. Calculate the number of personal care, homemaker, and health maintenance activities hours needed on a monthly basis using the Department's prescribed method. The needs determined for the Allocation should reflect the needs in the Department-approved Assessment tool and the service plan. The Case Manager shall use the Department's established rate for personal care, homemaker, and health maintenance activities to determine the Member's Allocation.

b. The Allocation should be determined using the Department's prescribed method at the Member's initial CDASS enrollment and at Reassessment. Service authorization will align with the Member's need for services and adhere to all service authorization requirements and limitations established by the Member's waiver program.

c. The Case Manager shall follow the Department's assessment process and receive prior authorization before authorizing a CDASS start date for Attendant services for Person-Centered Support Plan that;

i. Contain Health Maintenance Activities; or

ii. Exceed the cost of care received in an institutional setting.

4. Prior to orientation or when an Allocation changes, the Case Manager shall provide written Notification of the Allocation to the Member and the AR, if applicable.

5. A Member or AR who believes the Member needs a change in Attendant support, may request the Case Manager to perform a review of the Direct Care Services Calculator and CDASS Allocation for services. Review should be completed within five (5) business days.

a. If the review indicates that a change in Attendant support is justified, the following actions will be taken:

i. The Case Manager shall provide notice of the Allocation change to the Member/AR utilizing a long-term care notice of action form within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

ii. The Case Manager shall complete a Prior Authorization Request (PAR) revision indicating the increase in CDASS Allocation using the Department's Medicaid Management Information System and FMS Contractor system. Prior Authorization Request (PAR) revisions shall be completed within five (5) business days of the Allocation determination.

iii. The Member/AR shall amend the ASMP and submit it to the Case Manager.

b. The Training and Support Contractor is available to facilitate a review of services and provide mediation when there is a disagreement in the services authorized on the Direct Care Services Calculator.

c. The Case Manager will notify the Member of CDASS Allocation approval or disapproval by providing a long-term care notice of action form to

Members within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

6. In approving an increase in the Member's Allocation, the Case Manager shall consider the following:

   a. Any deterioration in the Member's functioning or change in availability of natural supports, meaning assistance provided to the Member without the requirement or expectation of compensation;

   b. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services; and

   c. The appropriate use and application of funds for CDASS services.

7. In reducing a Member's Allocation, the Case Manager shall consider:

   a. Improvement of functional condition or changes in the available natural supports;

   b. Inaccuracies or misrepresentation in the Member's previously reported condition or need for service; and

   c. The appropriate use and application of funds for CDASS services.

8. Case Managers shall cease payments for all existing Medicaid-funded personal care, homemaker, and/or health maintenance activities as of the Member's CDASS start date.

9. For effective coordination, monitoring and evaluation of Members receiving CDASS, the Case Manager shall:

   a. Contact the CDASS Member/AR once a month during the first three months to assess their CDASS management, their satisfaction with Attendants, and the quality of services received. Case Managers may refer Members/ARs to the FMS Contractor for assistance with payroll and to the Training and Support Contractor for training needs, budgeting, and support.

   b. Contact the Member/AR quarterly after the first three months to assess their implementation of Attendant services, CDASS management issues, quality of care, Allocation expenditures, and general satisfaction.

   c. Contact the Member/AR when a change in AR occurs and contact the Member/AR once a month for three months after the change takes place.

d. Review monthly FMS Contractor reports to monitor Allocation spending patterns and service utilization to ensure appropriate budgeting and follow up with the Member/AR when discrepancies occur.

e. Utilize Department overspending protocol when needed to assist CDASS Member/AR.

f. Follow protocols established by the Department for Case Management Activities.

10. Reassessment: The Case Manager will follow in-person and phone contact requirements based on the Member's waiver program or CFC requirements. Contacts shall include a review of care needs, the ASMP, and documentation from the physician, physician assistant, or advance practice nurse stating the Member's ability to direct care.

11. Case Managers shall participate in training and consulting opportunities with the Department's contracted Training and Support Contractor.

12. Case Managers must review all documentation and observations and use the Age-Appropriate Task Standards for Children for Members under the age of 18 and Task Standards for adults for Members age 18 years or older when determining appropriate authorization for tasks. If additional hours are needed beyond the Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults, Case Managers shall follow the CFC Direct Care Services Exception Request process described in 8.7607.A.

13. Case Managers must review all exception requests to exceed Weekly Caregiver Limit as outlined in Section 8.7419.

8.7515.R CDASS Attendant Reimbursement

1. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the Member/Authorized Representative (AR) hiring the Attendant. Wages shall be established in accordance with Colorado Department of Labor and Employment standards including, but not limited to, minimum wage and overtime requirements. Attendant wages may not be below the local, state, and federal requirements for the location where the service is provided. The Financial Management Services (FMS) Contractor shall make all payments from the Member's Allocation under the direction of the Member/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified in the Attendant Support Management Plan (ASMP).

2. Attendant timesheets that exceed the Member's monthly CDASS Allocation by 30% or more are not allowed and cannot be authorized by the Member or AR for reimbursement through the FMS Contractor unless prior approval is obtained from the Department or its designee.

3. Once the Member's yearly Allocation is used, further payment will not be made by the FMS Contractor, even if timesheets are submitted. Reimbursement to Attendants for services provided when a Member is no longer eligible for CDASS or when the Member's Allocation has been depleted are the responsibility of the Member/AR.

8.7515.S CDASS Reimbursement to Family Members

1. Family Members/Legal Guardians may be employed by the Member/Authorized Representative (AR) to provide CDASS, subject to the conditions below.

    a. The Family Member or Legal Guardian shall be employed by the Member/AR and be supervised by the Member/AR.

    b. The Family Member and/or Legal Guardian being reimbursed as a Personal Care, Homemaker, and/or Health Maintenance Activities attendant shall be reimbursed at an hourly rate with the following restrictions:

        i. Family Member wages shall be commensurate with the level of skill required for the task and should not deviate from that of a non-Family Member Attendant unless there is evidence that the Family Member has a higher level of skill.

        ii. A member of the Member's household may only be paid to furnish Extraordinary Care as defined at Section 8.7502.II, as determined by the Case Manager. Extraordinary Care shall be documented on the service plan.

    c. Reimbursement to Legally Responsible Persons for Homemaker services is limited to a maximum of 364 total hours per year, per member.

    d. A Member/AR who chooses a Family Member as a care provider, shall document the choice on the Attendant Support Management Plan (ASMP).

8.7516 Counseling Services

8.7516.A Counseling Services Eligibility

1. Counseling Services is a service available to Members enrolled in the HCBS Brain Injury Waiver.

8.7516.B Counseling Services Definition

1. Counseling services mean individualized services designed to assist Members and their support systems to more effectively manage stress related situations due to a Brain Injury diagnosis.

8.7516.C Counseling Services Inclusions

1. Counseling is available to the Member's Family and support network in conjunction with the Member if they: a) have a significant role in supporting the Member or b) live with or provide care to the Member. "Family" and "support network" includes a Parent, spouse, child, relative, foster family, in-laws, or other person who may have significant ongoing interaction with the Member.

2. Services may be provided in the Member's residence, in community settings, or in the provider's office.

3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.

4. The need for all Counseling Services must be documented in the Person-Centered Support Plan.

5. All Counseling Services must be provided by enrolled HCBS Provider Agencies.

6. Family training/counseling must be carried out for the direct benefit of the Members of the HCBS-Brain Injury program.

6. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the service plan and shall include updates as may be necessary to safely maintain the Member at home.

7. The service is limited to thirty 30 visits of individual, group, family, or a combination of counseling services. The Department may authorize additional units based on needs identified in the Person-Centered Support Plan or Provider Care Plan.

8.7516.D Counseling Services Exclusions and Limitations

1. Family training is not available to individuals who are employed to care for the Member.

8.7516.E Counseling Services Provider Agency Requirements

1. Professionals providing Counseling Services must hold the appropriate license or certification for their discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, or Licensed Clinical Psychologist. Master's or doctoral level counselors who meet experiential and educational requirements but lack the certification or credentialing as described above, may submit their professional qualifications via curriculum vitae or resume for consideration.

2. All professionals applying as Provider Agencies of Counseling Services must demonstrate or document a minimum of two years of experience in providing counseling to Members with a Brain Injury and their families.

8.7516.F Counseling Services Reimbursement

1. Reimbursement will be on an hourly basis per type of counseling service as established by the Department. Three distinct counseling services are allowable for Members enrolled in the HCBS-Brain Injury Waiver: Counseling Services including Family Counseling, Individual Counseling, and Group Counseling.

8.7517 Day Habilitation

8.7517.A Day Habilitation Eligibility

1. Day Habilitation is a covered benefit for Members enrolled in one of the following HCBS waivers:

    a. Developmental Disabilities Waiver

    b. Supported Living Services Waiver

8.7517.B Day Habilitation Inclusions

1. Day Habilitation shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the Member's private residence or other residential living arrangement.

2. Day Habilitation services and supports encompass three (3) types of habilitative services; Specialized Habilitation Services, Supported Community Connections, and Prevocational Services.

    a. Specialized Habilitation (SH) services are community-integrated services provided out of a non-residential setting, provided to enable the Member to attain the maximum functional level or to be supported in such a manner that allows the Member to gain an increased level of self-sufficiency. Specialized Habilitation services:

        i. Include the opportunity for Members to select from Age-Appropriate Activities and Materials, as defined in Section 8.7001.A.1 both within and outside of the setting;

        ii. Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, and maintenance skills; and

iii. May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the Person-Centered Support Plan.

b. Supported Community Connections (SCC) services are provided to support the abilities and skills necessary to enable the Member to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement, and volunteer activities. SCC services:

i. Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a Member's care plan or Person-Centered Support Plan;

ii. Are conducted in a variety of settings in which the Member interacts with persons without disabilities other than those individuals who are providing services to the Member. These types of services may include socialization, adaptive skills and personnel to accompany and support the Member in community settings;

iii. Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the Provider Agency as part of the established reimbursement rate; and

iv. May be provided in a group setting or on a one-to-one (1:1) basis as identified in the Person-Centered Support Plan.

v. Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

c. Prevocational services must comply with Supported Employment regulations at Section 8.7549.

d. Telehealth Day Habilitation services

i. Telehealth Specialized Habilitation services includes provider-hosted virtual meetings, groups, and activities where Members virtually engage and interact with Provider Agency staff, volunteers, and other Members.

ii. Telehealth Supported Community Connections services includes virtual meetings, groups and activities, that are hosted by non-provider entities where Members virtually engage and interact with persons without disabilities other than those individuals who are providing services to the Member.

8.7517.C Day Habilitation Exclusions and Limitations

1. Day Habilitation Services and Supports are to be provided outside of the person's living environment, unless otherwise indicated by the person's needs. If services cannot be provided outside of the living environment due to a person's medical or safety needs, this shall be documented.

2. Day Habilitation services may not be delivered virtually 100% of the time.

    a. Specialized Habilitation Provider Agencies must maintain a physical location where in-person services are offered.

    b. There will always be an option for in-person Day Habilitation services available.

8.7517.D Day Habilitation Provider Agency Requirements

1. Provider Agencies shall maintain documentation that includes the date and start/end times of activities completed, what activities were completed, and what Person-Centered Support Plan goals of the Member are being achieved through the activity(ies).

2. Integrated employment should be considered as the primary option for all persons receiving Day Habilitation Services and Supports.

3. If the Provider Agency provides services in the community to persons who may visit the offices of the Provider Agency (or another service operated facility), but the persons receive services at such location(s) for less than one hour per visit, requirements of Sections 8.7412.A.1-4 do not apply. The Provider Agency shall, however, ensure that the facility complies with the ADA and contains no hazards which could jeopardize the health or safety of persons visiting the site.

4. For physical facilities used as community integrated sites over which the Provider Agency exercises little or no control, the Provider Agency shall:

    a. Conduct an on-site visit to ensure that there is no recognizable safety or health hazards which could jeopardize the health or safety of individuals; and

    b. Address any safety or health hazards which could jeopardize the health or safety of individuals with the owner/operator of the physical facility.

5. Specialized Habilitation Services Provider Setting

    a. Specialized Habilitation settings must meet the criteria outlined in Section 8.7001.B.

b. The Specialized Habilitation location shall provide a clean and sanitary environment that is physically accessible to the Members, including those Members with supportive devices for ambulation or who are in wheelchairs.

c. The Specialized Habilitation location shall provide age-appropriate activities appropriate to the number and needs of the Members, at the times desired by the Members.

8.7517.E Day Habilitation Provider Agency Reimbursement Requirements

1. Supported Living Services Waiver:

   a. Day habilitation services, in combination with prevocational services and supported employment, are limited to seven thousand one hundred and twelve (7,112) units per support plan year. One (1) unit is equal to fifteen (15) minutes of service.

2. Developmental Disabilities Waiver:

   a. Day Habilitation services, in combination with Prevocational services, are limited to four thousand eight hundred (4,800) units. When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and

   b. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One (1) unit is equal to fifteen (15) minutes of service.

3. DD & SLS: Day Habilitation services have 3 tiers for service provision:

   a. Tier 1 - Specialized Habilitation and Supported Community Connections services are provided virtually via Telehealth. Tier 1 services should be billed at the Tier 2 rate, according to the Member's Support Level.

   b. Tier 2 - Traditional Specialized Habilitation and Supported Community Connections services provided in a group setting, apart from the Member's residence, and billed for at the Tier 2 rate, according to the Member's Support Level. Tier 2 Supported Community Connections services may also be provided to a single Member, utilizing the community as the learning environment. Tier 2 services are delivered in-person.

   c. Tier 3 - Supported Community Connections services.

      i. SCC services are provided 1:1, to a single Member, and billed for at the Tier 3 Supported Community Connections rate. Members

who receive Supported Community Connections services under Tier 3 are also required to stay within the Member's individual annual dollar limit for the combination of group and 1:1 Day Habilitation services. Tier 3 services must be delivered in-person.

1) One-on-one Supported Community Connections services may be billed for at the individualized rate and when this occurs the combination of group and 1:1 Day Habilitation services are required to stay within the Member's individual annual dollar limit, as well as the unit limit. Members who have an exceptional need to exceed one's individualized annual dollar limit may request additional funding through the Department's exception process.

8.7518 Day Treatment

8.7518.A Day Treatment Eligibility

1. Day Treatment is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.7518.B Day Treatment Definition

1. Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the Member lives.

8.7518.C Day Treatment Inclusions

1. Day Treatment includes the following components:

    a. Social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management).

    b. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, Case Management and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan.

2. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statute.

3. The provider shall coordinate with other community-based resources and providers.

    a. Counseling and Referrals to appropriate professionals when Crisis situations occur with the Member and Family or staff.

    b. Behavioral programming which contains specific guidelines on treatment parameters and methods.

4. Transportation between therapeutic tasks in the community shall be included in the rate for day treatment.

8.7518.D Day Treatment Provider Agency Requirements

1. Directors of day treatment programs shall have professional licensure in a health-related program in combination with at least 2 years of experience in head trauma rehabilitation programming.

2. Providers are required to have regular contact and meetings with the Members and their families to discuss care plan progress and revision.

8.7518.E Day Treatment Provider Reimbursement Requirements

1. Day treatment services will be paid on a per diem basis at a rate to be determined by the Department. In order for a Provider Agency to be paid for a day of treatment, a Member must have attended and received day treatment services for a minimum of 2 hours per day.

8.7519 Dental

8.7519A Dental Eligibility

1. Dental is available to Members enrolled in one of the following HCBS waivers:

    a. Developmental Disabilities Waiver

    b. Supported Living Services Waiver

8.7519.B Dental Definition

1. Dental care means services administered for diagnostic and preventative care to abate tooth decay, and medically appropriate treatments to restore dental health.

8.7519.C Dental Inclusions

1. Preventative services include:

    a. Dental insurance premiums, copayments/and coinsurance;

b. Periodic examination and diagnosis;

c. Radiographs when indicated;

d. Non-intravenous sedation;

e. Basic and deep cleanings;

f. Mouth guards;

g. Topical fluoride treatment; and

h. Retention or recovery of space between teeth when indicated

2. Basic services include:

a. Fillings;

b. Root canals;

c. Denture realigning or repairs;

d. Repairs/re-cementing crowns and bridges;

e. Non-emergency extractions including simple, surgical, full and partial;

f. Treatment of injuries; or

g. Restoration or recovery of decayed or fractured teeth.

3. Major services include:

a. Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or are necessary to increase the stability of crowns of, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with The Department procedures.

b. Crowns.

c. Bridges.

d. Dentures.

8.7519.D Dental Exclusions and Limitations

1. Dental services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined at Section 8.076.1.8, or available through a third party. General

limitations to dental services including frequency will follow the Department's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the Member.

2. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior authorization by the Administrative Service Organization.

3. Implants shall not be a benefit for Members who use tobacco daily due to the substantiated increased rate of implant failures for chronic tobacco users.

4. Subsequent implants are not a covered service. Exceptions would be exclusive to situations involving failure of the implant. In these instances, a formal grievance must be filed in order to determine if a full review is necessary to assess the cause of the implant failure.

5. Full mouth implants or crowns are not covered.

6. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodontic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

   a. Elimination of fractures of the jaw or face,

   b. Elimination or treatment of major handicapping malocclusion, or

   c. Congenital disfiguring oral deformities.

7. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

8. Preventative and basic services are limited to $2,000 per support plan year. Major services are limited to $10,000 for the five year renewal period of the waiver.

8.7520 Electronic Monitoring

8.7520.A Electronic Monitoring Eligibility

1. Electronic Monitoring is a covered benefit available to Members enrolled in CFC.

8.7520.B Electronic Monitoring Definitions

1. Electronic Monitoring services means electronic equipment, or adaptations, that are related to an eligible person's disability and/or that enable the Member to

remain at home, and includes the installation, purchase, or rental of electronic monitoring devices which:

a. Enable the Member to secure help in the event of an emergency;

b. May be used to provide reminders to the Member of medical appointments, treatments, or medication schedules;

c. Are required because of the Member's illness, impairment or disability as identified and documented in the Person-Centered Support Plan or service plan; and

d. Are essential to prevent institutionalization of the Member.

2. Electronic Monitoring Provider means a Provider Agency as defined in Section 8.7400 and Section 25.5-6-303. C.R.S., that has met the Provider Agency requirements for electronic monitoring services specified in Section 8.7520.E.

3. Medication Reminders means devices, controls, or appliances that remind or signal the participant to take actions related to medications

4. Personal Emergency Response System (PERS) means ongoing remote monitoring through a device designed to signal trained alarm monitoring personnel in an emergency situation.

8.7520.C Electronic Monitoring Inclusions

1. Electronic monitoring services shall include personal emergency response systems, medication reminder systems, or other devices which comply with the definition above and are not included in the non-benefit items below at Section 8.7520.D.

8.7520.D Electronic Monitoring Exclusions and Limitations

1. Electronic Monitoring services shall be authorized for Members who live alone or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision.

2. Electronic Monitoring services shall be authorized for Members who have the physical and mental capacity to utilize the particular system requested for that Member.

3. Electronic Monitoring services shall not be authorized as a CFC benefit if the service or device is available elsewhere as a state plan Medicaid benefit.

4. The following are not benefits of electronic monitoring services:

a. Augmentative communication devices and communication boards;

b. Hearing aids and accessories;

c. Phonic ears;

d. Environmental control units, unless required for the medical safety of a Member living alone unattended; or as part of Remote Supports;

e. Computers and computer software unrelated to the provision of Remote Supports;

f. Wheelchair lifts for automobiles or vans

g. Exercise equipment, such as exercise cycles; or

h. Hot tubs, Jacuzzis, or similar items.

8.7520.E Electronic Monitoring Provider Agency Requirements

1. Electronic Monitoring Provider Agencies shall conform to the following standards for electronic monitoring services:

a. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be Federal Communications Commission (FCC) registered.

b. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer and/or Provider Agency of Electronic Monitoring shall train the Member in the use of the device as requested by the Member.

c. All equipment, materials or appliances shall be tested for proper functioning at the time of installation, and at periodic intervals thereafter, and be maintained based on the manufacturer’s recommendations. Any malfunction shall be promptly repaired, and equipment shall be replaced when necessary, including buttons and batteries.

d. All telephone calls generated by monitoring equipment shall be toll-free, and all Members shall be allowed to run unrestricted tests on their equipment.

e. Electronic Monitoring Provider Agencies shall send written information to each Member's Case Manager about the system, how it works, and how it will be maintained.

8.7520.F Electronic Monitoring Reimbursement

1. Payment for Electronic Monitoring services shall be the lower of the billed charges or the prior authorized amount.

2. For Electronic Monitoring the unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly.

3. No reimbursement is available for Electronic Monitoring in Provider-owned, -Controlled, or Congregate Facilities.

8.7521 Expressive Therapy- Art, Music, Play Therapy

8.7521.A Expressive Therapy Eligibility

1. Expressive Therapy is a covered benefit available to Members enrolled in the HCBS Children with Complex Health Needs Waiver.

8.7521.B Expressive Therapy Definition

1. Expressive Therapy means creative art, music or play therapy which provides Members the ability to express their medical situation creatively and kinesthetically for the purpose of allowing the Member to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

8.7521.C Expressive Therapy Inclusions

1. Expressive Therapy may be provided in an individual or group setting.

8.7521.D Expressive Therapy Exclusions and Limitations

1. Expressive Therapy is limited to the Member’s assessed need up to a maximum of 39 hours per annual support plan year.

8.7521.E Expressive Therapy Provider Agency Requirements

1. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a Medicaid enrolled home health or hospice Agency.

    a. Individuals providing Expressive Therapy delivering art or play therapy services shall meet the requirements for individuals providing Therapeutic Life Limiting Illness Support services and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent Members.

    b. Individuals providing Expressive Therapy delivering music therapy services shall hold a Bachelor’s, Master’s or Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists,

and have at least one year of experience in the provision of music therapy to pediatric/adolescent Members.

8.7522 Extraordinary Cleaning

8.7522.A Extraordinary Cleaning Eligibility

1. Extraordinary Cleaning Services is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Children's Extensive Support Waiver

    b. Supported Living Services Waiver

8.7522.B Extraordinary Cleaning Definitions

1. Extraordinary Cleaning means specialized cleaning, disinfection, and sanitization services necessary to ensure a safe, hygienic living environment and prevent the spread of infectious diseases or pathogens. Extraordinary cleaning includes the use of commercial-grade products, infection control protocols, handling and disposal of biohazard materials, and specialized materials or equipment.

2. Personal Protective Equipment (PPE) is equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. Personal protective equipment may include items such as gloves, safety glasses and shoes, well-fitting masks or NIOSH-approved respirators, gowns, shoe covers, etc.

3. Commercial-Grade Product means a cleaning substance or mixture of substances registered with the Environmental Protection Agency (EPA) that destroys or irreversibly inactivates bacteria, fungi, and viruses. The product must be clearly labeled and registered with the EPA and must be stored in a location sufficiently secure to deny access to children, pets, or at-risk adults.

4. Standard Precautions means an infection-control principle that treats all blood, bodily fluids and other potentially infectious materials as infectious.

8.7522.C Extraordinary Cleaning Inclusions

1. Service shall be for the benefit of the Member and not for the benefit of other persons living in the home. Extraordinary Cleaning services must be completed within spaces a Member frequents such as their home or vehicle.

2. Extraordinary Cleaning tasks are beyond routine homemaking tasks and are necessary to ensure a safe and hygienic living environment due to or as a result of a Member's disability.

3. Services include professional and specialized cleaning, disinfection, and/or sanitization. Tasks require specialized knowledge, training, and use of

Commercial-Grade Products and equipment. Providers must use standard precautions and personal protective equipment in the provision of services, when applicable.

4. Extraordinary Cleaning services may be authorized due to a member's disabilities/behaviors causing an unsafe and unsanitary living environment for the Member which requires extraordinary cleaning to mitigate. The Member's needs must be documented in the Person-Centered Support plan and then outlined in the Provider Care Plan or included in sub-contractor documentation, along with details on how the service frequency and scope is appropriate to address concerns.

5. Extraordinary Cleaning tasks may include:

    a. Cleaning floors and other household surfaces including wood, laminate, engineered flooring materials, vinyl, tile, carpets or rugs, counters, and/or walls using Commercial-Grade Products and equipment.

        i. Cleaning, sanitization and disinfection of mattresses, surfaces, furniture, upholstery, and other household items requiring use of Commercial-Grade Products and equipment.

    b. Laundering and disinfecting a member's clothing, towels, bedding or linens soiled with blood or other bodily fluids. Laundry services or commercial/professional laundering may be appropriate to manage the laundering needs.

    c. Air duct cleaning that is essential for the health and safety of the member that mitigates disability-related health complications.

8.7522.D Extraordinary Cleaning Exclusions and Limitations

1. Extraordinary Cleaning service may NOT include:

    a. Personal care services.

    b. Homemaker services.

    c. Services the member can perform independently.

    d. Adaptations or improvements to the home that are considered to be on-going home maintenance and are not of direct medical or remedial benefit to the Member.

    e. Services that are not essential to the health and safety of the Member.

    f. Services that do not meet the task definition for Extraordinary Cleaning may not be approved.

g. Services that are deemed typical parental responsibility may not be approved.

h. Services that do not follow Age- Appropriate Guidelines may not be approved.

i. Extraordinary cleaning services provided in Uncertified Congregate Facilities may not be approved.

j. In the case a Member resides in a rental property, the responsibility of the landlord, pursuant to the lease agreement, must be examined prior to the authorization of service.

8.7522.E Extraordinary Cleaning Case Management Agency Responsibilities:

1. Detailed, task-related goals shall be documented by the case manager in the Person-Centered Support Plan, including documentation and goals of extraordinary cleaning projects as it relates to improving the health and safety of the Member.

2. Requests for costs that exceed an amount equal to 700 15-minute units over the course of a Support Plan year may be approved by the Department, as prescribed by the Department, if it:

   a. Ensures the health and safety of the Member in the home;

   b. Decreases the need for paid assistance in another HCBS waiver service or CFC on a long-term basis.

3. Case Management Agency approval for a higher amount shall include a thorough review of the current request to ensure cost effectiveness and no unnecessary duplication.

8.7522.F Extraordinary Cleaning Provider Agency Requirements

1. A provider enrolled with Colorado Medicaid or contracting with a Case Management Agency to provide the Extraordinary Cleaning service must be a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and hold a Certificate of Good Standing to do business in Colorado.

8.7522.G Extraordinary Cleaning Provider Services Reimbursement Requirements

1. HCBS Supported Living Services (SLS) Waiver; Children’s Extensive Support (CES) Waiver:

a. Payment does not include travel time to or from the Member's residence.
a. Payment does not include travel time to or from the Member's residence.

b. Reimbursement shall not exceed an amount equal to 700 15-minute units and may be billed as a 15-minute unit and/or project total for services rendered.

c. Work that was completed prior to authorization by the Department or Case Management Agency is not eligible for reimbursement.

8.7522 CHRP Habilitation

8.7522.A CHRP Habilitation Eligibility

1. CHRP Habilitation is a covered benefit available to Members enrolled in the HCBS Children's Habilitation Residential Program Waiver

8.7522.B CHRP Habilitation Inclusions

1. CHRP Habilitation is a 24-hour service that includes assisting a Member in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in Home and Community-Based settings. Service components include the following:

   a. Independent living training, which may include personal care, household services, infant and childcare when the Member has a child, and communication skills.

   b. Self-advocacy training and support which may include assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing Abuse, Neglect, Mistreatment, and/or Exploitation of self, responsibility for one's own actions, and participation in meetings.

2. Cognitive services which include assistance with additional concepts and materials to enhance communication. Cognitive Services are intended to help the Member better understand cause and effect and the connection between behaviors and consequences. Services may also include training in repetitive directions, staying on task, levels of receptive language capabilities, and retention of information.

3. Emergency assistance which includes safety planning, fire and disaster drills, and Crisis intervention.

4. Community Access Supports includes assistance developing the abilities and skills necessary to enable the Member to access typical activities and functions of community life such as education, training, and volunteer activities.

Community access supports includes providing a wide variety of opportunities to develop socially appropriate behaviors, facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in Member's Person-Centered Support Plan or Provider Care Plan. These activities are conducted in a variety of settings in which the Member interacts with non-disabled individuals (other than those individuals who are providing services to the Member). These services may include socialization, adaptive skills, and personnel to accompany and support the Member in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement and are based on the interest of the Member.

5. Transportation services are encompassed within Habilitation and are not duplicative of the non-emergent medical transportation that is authorized in the Medicaid State Plan. Transportation services facilitate Member access to activities and functions of community life.

6. Follow-up counseling, behavioral, or other therapeutic interventions, and physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

7. Medical and health care services that are integral to meeting the daily needs of the Member and include such tasks as routine administration of medications or providing support when the Member is ill.

8.7522.C CHRP Habilitation Service Requirements

1. Services may be provided to Members who require additional care for the Member to remain safely in Home and Community-Based settings. The Member must demonstrate the need for such services above and beyond those of a typical child of the same age.

2. Habilitation services under the CHRP waiver differ in scope, nature, supervision, and/or Provider Agency type (including provider training requirements and qualifications) from any other services in the Medicaid State Plan.

3. Habilitation may be provided in a Foster Care Home or Kinship Foster Care Home certified by a licensed Child Placement Agency or County Department of Human Services, Specialized Group Facility licensed by the Colorado Department of Human Services, or Residential Child Care Facility licensed by the Colorado Department of Human Services.

4. Habilitation may be provided for Members aged eighteen (18) to twenty (20) in a Host Home. The Host Home must meet all requirements as defined in Sections 8.7541 Residential Habilitation Services and Supports (RHSS) and 8.7542 Individual Residential Service and Supports (IRSS).

5. Provider Agencies and child placement agencies must comply with the habilitation capacity limits at 12 C.C.R. 2509-5; Section 7.406.2.M.

8.7522.D CHRP Habilitation Provider Agency Requirements

1. The Provider Agency or child placement Agency shall ensure choice is provided to all Members in their living arrangement.

2. The Foster Care Home or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all Members living in the home.

3. The Provider Agency shall provide the Case Management Agency a copy of the Foster Care Home or Kinship Foster Care Home certification before any child or youth may be placed in that home. If emergency placement is needed outside of business hours, the Provider Agency or child placement Agency shall provide the Case Management Agency a copy of the Foster Care Home or Kinship Foster Care Home certification the next business day.

4. Provider Agencies for habilitation services and services provided outside the Family home shall meet all of the certification, licensing, waiver, and quality assurance regulations related to their provider type.

5. Service in a foster care home may be provided by a provider that is licensed by the State Department of Human Services or certified by the county or Child Placement Agency. For youth aged 18-20, service may be provided in a host home.

8.7522.E CHRP Habilitation Reimbursement

1. A Support Need Level Assessment must be completed upon determination of eligibility. The Support Need Level Assessment is used to determine the level of reimbursement for Habilitation services.

2. Reimbursement for Habilitation service does not include the cost of normal facility maintenance, upkeep, and improvement. This exclusion does not include costs for modifications or adaptations required to assure the health and safety of the Member or to meet the requirements of the applicable life safety code.

3. Room and board shall not be a benefit of habilitation services. Members shall be responsible for room and board, per Section 8.7413.

8.7523 Health Maintenance Activities Self-Directed

8.7523.A Health Maintenance Activities Eligibility

1. Health Maintenance is available to Members eligible for Consumer Directed Attendant Support Services (CDASS) or In-Home Support Services (IHSS) within CFC.

8.7523.B Health Maintenance Activities Definition

1. Health Maintenance means routine and repetitive health-related tasks furnished to a Member in the community or in the Member's home that is necessary for the health and normal bodily functioning that a person with a disability is physically unable to carry out. "Health Maintenance Activities" include skilled tasks typically performed by a certified nursing assistant or a licensed nurse that does not require the clinical assessment and judgment of a licensed nurse.

    a. Member's record must include clinical documentation to substantiate any Health Maintenance Activities on the Care Plan. This includes all applicable documentation associated with the Direct Care Services Calculator, as defined at Section 8.7502.K.

2. Home Exercise Plan is an exercise plan that is developed by a Licensed Medical Professional, an occupational therapist, a speech language pathologist, a Registered Nurse, or physical therapist that instructs the Member what exercises must be completed in the home or in the community. The exercises identified in the Home Exercise Plan must not replace the services that are traditionally received through Occupational Therapy, Physical Therapy, and/or Speech Therapy services.

8.7523.C Health Maintenance Activities Inclusions

1. Services may include:

    a. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection and the Member is unable to apply creams, lotions, sprays, or medications independently due to illness, injury, or disability. Skin care may include wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when directed by a Licensed Medical Professional (LMP).

    b. Hair care includes shampooing, conditioning, drying, and combing when performed in conjunction with health maintenance level bathing, dressing, or skin care. Hair care may be performed when:

        i. The Member is unable to complete task independently;

        ii. Application of a prescribed shampoo/conditioner which has been dispensed by a pharmacy; or

        iii. The Member has open wound(s) or neck stoma(s).

    c. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing, and trimming.

d. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:

i. There is injury or disease of the face, mouth, head, or neck;

ii. In the presence of communicable disease;

iii. When the Member is unable to participate in the task;

iv. Oral suctioning is required;

v. There is decreased oral sensitivity or hypersensitivity;

vi. The Member is at risk for choking and aspiration.

e. Shaving performed when health maintenance level skin care is required in conjunction with the shaving, or:

i. The Member has a medical condition involving peripheral circulatory problems;

ii. The Member has a medical condition involving loss of sensation;

iii. The Member has an illness or takes medications that are associated with a high risk for bleeding;

iv. The Member has broken skin at/near shaving site or a chronic active skin condition.

f. Dressing performed when health maintenance-level skin care or transfers are required in conjunction with the dressing, or:

i. Assistance with the application of prescribed anti-embolic or pressure stockings is required;

ii. Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.

g. Feeding is considered a health maintenance task when the Member requires health maintenance-level skin care or dressing in conjunction with the task, or:

i. Oral suctioning is needed on a stand-by or intermittent basis;

ii. The Member is on a prescribed modified texture diet;

iii. The Member has a physiological or neurogenic chewing or swallowing problem;

iv. Syringe feeding or feeding using adaptive utensils is required;

v. Oral feeding when the Member is unable to communicate verbally, non-verbally or through other means.

h. Exercise including passive range of motion. Exercises must be specific to the Member's documented medical condition and require hands-on assistance to complete. A Home Exercise Plan must be developed by a Licensed Medical Professional, Occupational Therapist, a speech language pathologist, a Registered Nurse, or Physical Therapist.

i. Registered nurses who are affiliated with the Home Care Agency in which the member receives services are not permitted to develop the home exercise plan for the member in which they are serving.

i. Transferring a Member when they are not able to perform transfers independently due to illness, injury, or disability, or:

i. The Member lacks the strength and stability to stand, maintain balance or bear weight reliably;

ii. The Member has not been deemed independent with Adaptive Equipment or assistive devices by a Licensed Medical Professional;

iii. The use of a mechanical lift is needed.

j. Bowel care performed when health maintenance-level skin care or transfers are required in conjunction with the bowel care, or:

i. The Member is unable to assist or direct care;

ii. Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;

iii. Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.

k. Bladder care performed when health maintenance-level skin care or transfers are required in conjunction with bladder care, or;

i. The Member is unable to assist or direct care;

ii. Care of external, indwelling, and suprapubic catheters;

iii. Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.

l. Medical management as directed by a Licensed Medical Professional to routinely monitor a documented health condition, including but not limited to: blood pressures, pulses, respiratory rate, blood sugars, oxygen saturations, intravenous or intramuscular injections.

m. Respiratory care:

i. Postural drainage;

ii. Cupping;

iii. Adjusting oxygen flow within established parameters;

iv. Suctioning mouth and/or nose;

v. Nebulizers;

vi. Ventilator and tracheostomy care;

vii. Assistance with set-up and use of respiratory equipment.

n. Bathing assistance is considered a health maintenance task when the Member requires health maintenance-level skin care, transfers or dressing in conjunction with bathing.

o. Medication assistance, which may include setup, handling and administering medications.

i. For In-Home Support Services (IHSS) only, The IHSS Agencies Licensed Health Care Professional must validate Attendant skills for medication administration and ensure that the completion of task does not require clinical judgment or Assessment skills.

p. Accompanying includes going with the Member, as necessary according to the care plan, to medical appointments, and errands such as banking and household shopping. Accompanying the Member may also include providing one or more health maintenance tasks as needed during the trip. Attendants must assist with communication, documentation, verbal prompting and/or hands on assistance when the task may not be completed without the support of the Attendant.

q. Mobility assistance is considered a health maintenance task when health maintenance-level transfers are required in conjunction with the mobility assistance, or:

i. The Member is unable to assist or direct care;

ii. When hands-on assistance is required for safe ambulation and the Member is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or

iii. The Member has not been deemed independent with Adaptive Equipment or assistive devices ordered by a Licensed Medical Professional

r. Positioning includes moving the Member from the starting position to a new position while maintaining proper body alignment, support to a Member's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;

i. The Member is unable to assist or direct care, or

ii. The Member is unable to complete task independently

2. Additional HMA inclusion criteria for children are available within the Health Maintenance Activities Documentation Guide.

8.7523.D Health Maintenance Activities Exclusions and Limitations

1. This service is subject to the following Annual CFC Service Soft Caps: Members shall not be authorized for more than 4,750 hours of Health Maintenance Activities per Person-Centered Support Plan year. Case Managers may request additional hours through the Department prescribed exception process as defined at Section 8.7607.A.

2. Attendants must adhere to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

8.7524 Adaptive Therapeutic Equine Activities

8.7524.A Adaptive Therapeutic Equine Activities Eligibility

1. Adaptive Therapeutic Equine Activities are a covered benefit available to Members enrolled in one of the following HCBS waivers:

a. Children's Extensive Support Waiver

b. Children's Habilitation Residential Program Waiver

c. Supported Living Services Waiver

8.7524.B Adaptive Therapeutic Equine Activities Definition

1. Adaptive Therapeutic Equine Activities are therapeutic activities that use the horse to assist in the development and enhancement of skills which help support

improved motor skills, self-regulation, communication opportunities and social and emotional wellbeing. This service is used as a strategy for skill acquisition and skill maintenance and outlined in the individualized Person-Centered Support Plan (PCSP).

8.7524.C Adaptive Therapeutic Equine Activities Inclusions

1. Adaptive Therapeutic Equine Activities are included when it meets an identified need in the Person-Centered Support Plan.

8.7524.D Adaptive Therapeutic Equine Activities Exclusions and Limitations

1. HCBS Children's Extensive Services (CES) Waiver; HCBS Supportive Living Services (SLS); HCBS Children's Habilitation Residential Program (CHRP) Waiver:

    a. The following items are excluded under the HCBS waivers and are not eligible for reimbursement:

        i. Hippotherapy.

        ii. Experimental treatments or therapies; and,

        iii. Facility access fees, including barn and stable fees

    b. Adaptive Therapeutic Equine Activities are not covered as a waiver service if it is available under the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), or from a Third-Party Resource.

8.7524.E Adaptive Therapeutic Equine Activities Service Provider Agency Requirements

1. Adaptive Therapeutic Equine Activities must be recommended or prescribed by a licensed physician or therapist.

2. The recommendation must clearly identify the need for Adaptive Therapeutic Equine Activities, a recommended treatment protocol, and expected outcome or goal.

3, The provider is licensed, certified, registered or accredited, and in good standing, according to all applicable state licensing requirements for the performance of the Therapeutic Adaptive Equine Activities support and services provided.

8.7525 Home Accessibility Modifications and Adaptations

8.7525.A Home Accessibility Modifications and Adaptations Eligibility

1. Home Accessibility Modifications and Adaptations is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Brain Injury Waiver

    b. Children's Extensive Support Waiver

    c. Community Mental Health Supports Waiver

    d. Complementary and Integrative Health Waiver

    e. Elderly, Blind, and Disabled Waiver

    f. Supported Living Services Waiver

8.7525.B Home Accessibility Modifications and Adaptations Definitions

1. The Division of Housing (DOH) is a State entity within the Department of Local Affairs that is responsible for approving Home Modification requests oversight on the quality of Home Modification projects, and inspecting Home Modification projects, as described in

2. Eligible Member means a Member who is enrolled in the following Home and Community-Based Services waivers: Brain Injury, Complementary and Integrative Health, Community Mental Health Supports, or Elderly, Blind and Disabled, Supported Living Services (SLS) and Children's Extensive Supports (CES).

3. Home Modification means specific modifications, adaptations or improvements in an eligible Member's existing home setting which, based on the Member's medical condition:

    a. Are necessary to ensure the health, welfare and safety of the Member and

    b. Enable the Member to function with greater independence in the home, and

    c. Are required because of the Member's illness, impairment or disability, as documented on the Assessment and Person-Centered Support Plan; and

    d. Prevents institutionalization or supports the deinstitutionalization of the Member.

8.7525.C Home Accessibility Modifications and Adaptations Inclusions

1. Home Modifications, adaptations, or improvements may include but are not limited to the following:

    a. Installing or building ramps.

b. Installing grab-bars and installing other Durable Medical Equipment (DME) items if such installation shall not be performed by a DME supplier.

c. Widening doorways.

d. Modifying a bathroom facility for the purposes of accessibility, health and safety, and independence in Activities of Daily Living.

e. Modifying kitchen facilities.

f. Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies.

g. Installing stair lifts or vertical platform lifts.

h. Modifying an existing second exit or egress window for emergency purposes.

i. The modification of a second exit or egress window must be approved by the Department, or its agent as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare of the Member.

2. Previously completed home modifications, regardless of original funding source, shall be eligible for maintenance or repair within the remaining balance of the Member's available cap for home modifications while remaining subject to Section 8.7525.C. The cap will be noted in the Home Modification page of the Department's website.

3. Home Modification Funding Limits

a. HCBS Supported Living Services (SLS) and Children's Extensive Services (CES) Waivers:

ii. The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed the cap determined by the Department per member.

ii. Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the member, or enable the member to function with greater independence in the home, if:

1) The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and

2) Either:

i) There is an immediate risk to the member's health or safety, or

ii) There has been a significant change in the member's needs since a previous Home Accessibility Adaptation.

i. The cost of the home modification shall not exceed the cap determined by the Department per member. The current cap will be posted on the Home Modification page of the Department's website and will reset when each waiver resets, every 5 years.

ii. The Department may authorize funds in excess of the member's cap if there is:

1) An immediate risk of the member being institutionalized; or

ii) A significant change in the member's needs since a previous home modification.

8.7525.D Home Accessibility Modifications and Adaptations Exclusions and Limitations

1. Home Modifications must be a direct benefit to the Member and not for the benefit or convenience of caregivers or other residents of the home.

2. Duplicate adaptations, improvements, or modifications are not a benefit. This includes, but is not limited to, multiple bathrooms within the same home.

3. Adaptations, improvements, or modifications as a part of new construction costs are not a benefit.

a. Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.

b. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i. improve entrance or egress to a residence; or,

ii. configure a bathroom to accommodate a wheelchair.

c. Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department procedures.

4. The purchase of items available through Durable Medical Equipment (DME) is not a benefit.

5. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

   a. Roof repair,

   b. Central air conditioning,

   c. Air duct cleaning,

   d. Whole house humidifiers,

   e. Whole house air purifiers,

   f. Installation and repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,

   g. Monthly or ongoing home security monitoring fees,

   h. Home furnishings of any type,

   i. HOA fees,

   j. Walk-In Tubs.

   k. Adaptations or improvements to the home that are considered to be on-going home repair or maintenance and are not related to the Member's ability and needs are prohibited.

   l. Upgrades beyond what is the most cost-effective means of meeting the Member’s identified need, including, but not limited to, items or finishes required by a Homeowner Association’s (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

6. The Department may deny requests for Home Modification projects that exceed usual and customary charges or do not meet local building requirements, the Long-Term Services and Supports Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards.

7. Home Modification projects are prohibited in any Provider -Owned or -Controlled setting.

8. Volunteer work on a Home Modification project approved by the Department shall be completed under the supervision of the Home Modification Provider Agency as stated on the bid.

a. Volunteer work performed by Department-approved organizations must be described according to Department prescribed processes and procedures. A list of these organizations may be found on the Department website.

b. Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or Family Member, or work performed by a private contractor hired by the Member or family, must be described and agreed upon, in writing, by the Provider Agency responsible for completing the home modification, according to Department prescribed processes and procedures and must be approved by the Department.

9. If a Member lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by the Fair Housing Act, the Member's Home Modification funds may not be used unless reasonable accommodations have been denied.

8.7525.E Home Accessibility Modifications and Adaptations Case Management Agency Responsibilities

1. The Case Manager shall consider alternative funding sources to complete the Home Modification. These alternatives and the reason they are not available shall be documented in the case record.

   a. The Case Manager must confirm that the Member is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by the Fair Housing Act.

2. The Case Manager may approve Home Modification projects estimated at less than $2,500 without Department approval, contingent on Member authorization and confirmation of Home Modification fund availability.

3. The Case Manager shall obtain prior approval by submitting a prior request to the Department for Home Modification projects estimated to cost over $2500.

   a. The Case Manager must submit the request and all supporting documentation according to Department prescribed processes and procedures. Home Modification requests submitted with improper documentation cannot be authorized.

   b. The Case Manager and Case Management Agency are responsible for retaining and tracking all documentation related to a Member's previous home modification benefit lifetime use and communicating that information to the Member and Provider Agencies. The Case Manager may request confirmation of a Member's home modification use from the Department, its fiscal agent, or Division of Housing.

4. Home Modifications estimated to cost $2,500 or more shall be evaluated according to the following procedures:

    a. An occupational or physical therapist (OT/PT) shall assess the Member's needs and the therapeutic value of the requested Home Modification. When an OT/PT with experience in Home Modification is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Modification would contribute to a Member's ability to remain in or return to their home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the Home Modification request..

    b. The evaluation services may be provided by a home health Agency or other qualified and approved OT/PT through the Medicaid Home Health benefit consistently with Home Health rules set forth in Section 8.520, including physician orders and plans of care.

        i. A Case Manager may initiate the OT/PT evaluation process before the Member has been approved for Waiver Services, as long as the Member is Medicaid Eligible.

        ii. A Case Manager may initiate the OT/PT evaluation process before the Member physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

    c. The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Member's needs.

5. The Case Manager shall solicit bids according to the following procedures:

    a. The Case Manager shall solicit bids from at least two Home Modification Provider Agencies.

        i. The Case Manager must verify that the provider is an enrolled Home Modification Provider Agency.

        ii. The bids must be submitted according to Department prescribed processes and procedures.

    b. The bids shall include a breakdown of the costs of the project including:

        i. Description of the work to be completed.

        ii. Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.

iii. Estimate for building permits, if needed.

iv. Estimated timeline for completing the project.

v. Name, address, and telephone number of the Home Modification Provider Agency.

vi. Signature, including option for digital signature, of the Home Modification Provider Agency.

vii. Signature, including option for digital signature, of the Member or Guardian or other indication of approval.

viii. Signature, including option for digital signature, of the homeowner or property manager if applicable.

c. Home Modification Provider Agencies have a maximum of 30 days to submit a bid for the Home Modification project after the Case Manager has solicited the bid.

i. If the Case Manager has made three attempts to obtain a written bid from a Home Modification Provider Agency and the Home Modification Provider Agency has not responded within 30 calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the Home Modification request.

d. The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation to the Department or its agent. The Department or its agent shall authorize the lowest bid that complies with the requirements of Section 8.7525 and the recommendations of the OT/PT evaluation.

i. If a Member or homeowner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the Home Modification request.

e. A revised bid and Change Order request shall be submitted according to the procedures described in this section for any changes from the original approved Prior Authorization Request (PAR) according to Department prescribed processes and procedures.

6. If a property to be modified is not owned by the Member, the Case Manager shall obtain signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein. Signatures may be completed using a digital signature based on preference of the individual signing the form.

a. Written consent of the homeowner or property manager, as evidenced by the above-mentioned signatures, is required for all projects that involve permanent installation within the Member's residence or installation or modification of any equipment in a common or exterior area.

b. If the Member vacates the property, these signatures can be used as evidence that the homeowner or property manager agrees to allow the Member to leave the modification in place or remove the modification as the Member chooses. If the Member chooses to remove the modification, the property must be left equivalent or better to its pre-modified condition. The homeowner or property manager may not hold any party responsible for removing all or part of a home modification project.

7. If the Case Management Agency does not comply with the process described above resulting in increased cost for a home modification, the Department may hold the Case Management Agency financially liable for the increased cost.

8. The Department or its agent may conduct on-site visits, or any other investigations deemed necessary prior to approving or denying the Home Modification request.

8.7525.F Home Accessibility Modifications and Adaptations Provider Agency Requirements

1. Home Modification Providers Agencies shall conform to Provider Agency regulations set forth in Section 8.7400.

2. Home Modification Provider Agencies shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county.

3. Home Modification Provider Agencies shall begin work within 60 days of signed approval from the Department. Upon request by Provider Agency, the the Division of Housing or the Department may grant an extension for circumstances outside of the Provider Agencies' control. Requests must be received prior to the expiration of the 60-day deadline and be supported by documentation, including Member notification. Reimbursement may be reduced for delays in accordance with Section 8.7525.F.6.

a. If any changes to the approved scope of work are made without Department authorization, the cost of those changes will not be reimbursed.

b. Projects shall be completed within 30 days of beginning work. Upon request by a Provider Agency, the Division of Housing or the Department may grant an extension for circumstances outside of the Provider Agencies' control. Requests must be received prior to the expiration of the

30-day deadline and be supported by documentation, including Member notification. Reimbursement may be reduced for delays.

4. The Home Modification Provider Agency shall provide a one-year written warranty on materials and labor from the date of final inspection on all completed work and perform work covered under that warranty at their expense.

5. The Home Modification Provider Agency shall comply with the Long Term Services and Supports Home Modification Benefit Construction Specifications developed by the Division of Housing, which may be found on the Department website, and with local, and state building codes.

6. All Home Modification projects within a Department-established sampling threshold shall be inspected upon completion by Division Of Housing, a state, local or county building inspector or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Modification projects may be inspected by Division Of Housing upon request by the Member at any time determined to be reasonable by DOH or the Department. Members must provide access for inspections.

    a. Division Of Housing shall perform an inspection within 14 days of receipt of notification of project completion or receipt of a Member's reasonable request.

    b. Division of Housing shall produce a written inspection report within three days of performing an inspection that notes the Member's specific Complaints. The inspection report shall be sent to the Member, Case Manager, and Provider Agency.

    c. Home Modification Provider Agencies must repair or correct any noted deficiencies within 20 days, or the time required by the inspection, whichever is shorter. Upon request by the Provider Agency, the DOH or the Department may grant an extension for circumstances outside of the Provider Agencies' control. Requests must be received prior to the original deadline and be supported by documentation, including Member notification. Reimbursement may be reduced for delays in accordance.

7. Copies of building permits and inspection reports shall be submitted to Division of Housing. If a permit is not required, the Home Modification Provider Agency shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be justification for recovery of payment by the Department.

8.7525.G Home Accessibility Modifications and Adaptations Reimbursement

1. Payment for Home Modification services shall be the prior authorized amount, or the amount billed, whichever is lower. Reimbursement shall be made in two payments per Home Modification.

2. The Home Modification Provider Agency may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

3. The Home Modification Provider Agency may submit a claim for final payment when the Home Modification project has been completed satisfactorily as shown by the submission of the documentation below to Division of Housing:

    a. Signed lien waivers for all labor and materials, including lien waivers from subcontractors;

    b. Required permits;

    c. Photographs taken before and after the Home Modification has been completed;

    d. One-year written warranty on materials and labor; and

    e. Documentation in the Member's file that the Home Modification has been completed satisfactorily through:

        i. Receipt of inspection report approving work from the building inspector or other inspector as referenced at Section 8.7525.F.6;

        ii. Approval by the Member, Guardian, representative, or other designee;

        iii. Approval by the homeowner or property manager; or

        iv. By conducting an on-site inspection.

4. If Division of Housing notifies a Home Modification Provider Agency that an additional inspection is required, the Home Modification Provider Agency may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

5. The Home Modification Provider Agency shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Modification Provider Bid form or Home Modification Provider Change Order form.

    a. All recommended repairs noted on inspections shall be completed before the Home Modification Provider Agency submits a final claim for reimbursement.

    b. If a Home Modification Provider Agency has not completed work satisfactorily, Division of Housing shall determine the value of the work completed satisfactorily by the Provider Agency during an inspection. The

Provider Agency shall only be reimbursed for the value of the work completed satisfactorily.

i. A Home Modification Provider Agency may request Division of Housing perform one redetermination of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the Provider Agency's expense.

6. Reimbursement may be reduced at a rate of 1% of the total project amount every 7 calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies and inspection deficiencies.

   a. Upon request by a Provider Agency, the Division of Housing or the Department may grant an extension for circumstances outside of the Provider Agency's control. Requests must be received within the original deadline period and be supported by documentation, including Member notification.

   b. The Home Modification reimbursement reduced pursuant to this subsection shall be incorporated into the computation of the Member's remaining money.

7. The Home Modification Provider Agency shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Member. The Home Modification Provider Agency may be reimbursed for the installation of Durable Medical Equipment if such installation is outside of the scope of the Member's Durable Medical Equipment benefit.

8. Work that was completed prior to Department approval is not eligible for reimbursement.

8.7526 Home Delivered Meals

8.7526.A Home Delivered Meals Eligibility

1. Home Delivered Meals is a covered benefit available to Members enrolled in CFC.

8.7526.B Home Delivered Meals Definition

1. Home Delivered Meals means delivery of meals to Members who have dietary restrictions or specific nutritional needs, are unable to prepare their own meals, and have limited or no outside assistance. At the Member's request, this service may also include nutrtitional counseling and meal planning

8.7526.C Home Delivered Meals Inclusions

1. Home Delivered Meals may include:

    a. Meals intended to support member wellness, which may include meals tailored to the member's nutritional needs.

    b. Meal planning developed for the Member's individual needs which may include nutritional meal planning, nutritional counseling, selected meal types, and instructions for meal preparation and delivery.

2. To obtain approval for Home Delivered Meals, the Member must demonstrate a need for the service, as follows:

    a. The member is transitioning from an institutional setting to a home and community-based setting; and/or

    b. The member demonstrates the following:

        i. The Member lacks or has limited access to outside assistance, services, or resources through which they can access meals; and

        ii. The Member is unable to prepare meals to sustain health, or has dietary restrictions, or has specific nutritional needs; and

        iii. The Member's inability to access and/or prepare nutritious meals demonstrates a risk to the member's health or safety, or institutionalization; decreasing independence and increasing the need for human intervention or assistance.

8.7526.D Home Delivered Meals Service Requirements

1. The Member's Provider Care Plan must specifically identify:

    a. Any individualized nutritional counseling or nutritional meal plan requested by the Member, which describes the Member's nutritional needs and selected meal types, and provides instructions for meal preparation and delivery; and

    b. The Member's specifications for preparation and delivery of meals, and any other detail necessary to effectively implement the individualized meal plan.

2. The service must be provided in the home or community and in accordance with the Member's Person-Centered Support Plan. All Home Delivered Meal services shall be documented in the Provider Care Plan.

3. The assessed need is documented in the Member's service plan as part of their skills acquisition process of gradually becoming capable of preparing their own meals or establishing the resources to obtain their needed meals.

4. Members may be approved for Home Delivered Meals for no more than 365 days. Home Delivered Meals may be authorized past 365 days on a case-by-case basis if there is a demonstrated need.

5. Meals are to be delivered up to two meals per day, with a maximum of 14 meals delivered per week.

6. Meals may include liquid, mechanical soft, or other medically necessary types.

7. Meals may include ethnic or cultural options.

8. Meals may be delivered hot, cold, frozen, or shelf-stable, depending on the Member's or caregiver's ability to complete the preparation of, and properly store the meal.

9. The Provider Agency shall confirm meal delivery, by attestation of the deliverer or carrier proof of delivery, to ensure the Member receives the meal in a timely fashion, and to determine whether the Member is satisfied with the quality of the meal.

10. TThe Home Delivered Meals provider will check in with the Member no less frequently than every 90 days to ensure the meals are satisfactory, that they promote the Member's health, and that the service is meeting the Member's needs.

11. The case manager will review a Member's progress toward the nutritional goal(s) described in the Member's Provider Care Plan no less frequently than once per calendar quarter, and more frequently, as needed. If the case manager has concerns regarding the Member's progress toward the nutritional goal(s), they should refer back to the Home Delivered Meals provider to schedule a nutritional counseling session with a RD or RDN.

12. The RD or RDN shall make changes to the Nutritional Meal Plan if the quarterly assessment results show changes are necessary or appropriate.

    a. The Home Delivered Meals provider will send the Nutritional Meal Plan to the Case Management Agency no less frequently than once per quarter to allow the Case Management Agency to verify the plan with the Member during the quarterly check-in. The case manager will make corresponding updates to the Person-Centered Support Plan, as needed.

8.7526.E Home Delivered Meals Exclusions and Limitations

1. Home Delivered Meals are not available when the Member resides in a provider-owned or controlled setting.

2. Delivery must not constitute a full nutritional regimen and includes no more than two meals per day or 14 meals per week.

3. Items or services through which the Member's need for Home Delivered Meal services may otherwise be met, including any item or service available under the State Plan, applicable HCBS waiver, or other resources are excluded.

4. Meals not identified in the Nutritional Meal Plan or any item outside of the meals not identified in the meal plan, such as additional food items or cooking appliances are excluded.

5. Meal plans and meals provided are reimbursable when they benefit the Member, only. Services provided to someone other than the Member are not reimbursable.

8.7526.F Home Delivered Meals Provider Agency Requirements

1. A licensed provider enrolled with Colorado Medicaid to provide the Home Delivered Meal service must be a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and holding a Certificate of Good Standing to do business in Colorado.

2. Home Delivered Meal Provider Agencies must conform to all general Certification standards, conditions, and processes established in Section 8.7400.

3. The Provider Agency shall maintain licensure as required by the State of Colorado Department of Public Health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for staff; or be approved by Medicaid as a home delivered meals provider in their home state.

4. The Provider Agency must maintain a Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN) on staff or under contract.

5. The Provider Agency shall maintain meals documentation in accordance with Section 8.7405 and shall provide documentation to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request. Required documentation includes:

    a. Documentation pertaining to the Provider Agency, including employee files, claim submission documents, program and financial records, insurance policies, and licenses, including a Retail Food License and Food Handling License for Staff, or, if otherwise applicable, documentation of compliance and good standing with the City and County municipality in which this service is provided; and

    b. Documentation pertaining to services, including:

        i. Documentation of any professionally recommended dietary restrictions or specific nutritional needs;

        ii. Member demographic information;

iii. A Meal Delivery Schedule;

iv. Documentation of special diet requirements;

v. A determination of the type of meal to be provided (e.g. hot, cold, frozen, shelf stable);

vi. A record of the date(s) and place(s) of service delivery (e.g. through documented driver attenstation or proof of carrier delivery);

vii. Monitoring and follow-up (contacting the Member after meal deliver to ensure the Member is satisfied with the meal); and

viii. Provision of nutrition counseling or documentation of Member declination.

8.7526.G Home Delivered Meals Provider Agency Reimbursement

1. Home Delivered Meals services are reimbursed based on the number of units of service provided, with one unit equal to one meal.

2. Payment for Home Delivered Meals shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the Provider Care Plan.

8.7527 Homemaker Services

8.7527.A Homemaker Services Eligibility

1. Homemaker Services is a covered benefit available to Members enrolled in CFC.

8.7527.B Homemaker Services Definitions

1. Homemaker Provider Agency means a Provider Agency that is certified by the state fiscal agent to provide Homemaker Services.

2. Homemaker means services provided to an eligible Member that include general household activities to maintain a healthy and safe home environment for a Member.

8.7527.C Homemaker Services Inclusions

1. Service shall be for the benefit of the Member and not for the benefit of other persons living in the home. Homemaker services, except for laundry, shopping, and Acquisition, Maintenance, and Enhancement of Skills (AME) must be completed within the permanent living space.

2. Homemaker tasks may include:

a. Routine light house cleaning, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas.

b. Meal preparation and menu planning.

c. Dishwashing.

d. Bedmaking.

e. Laundry.

f. Shopping.

g. Banking/Money Management.

i. For CDASS: caregivers cannot be reimbursed to provide money management tasks that would typically be completed by an authorized representative as defined in 8.7515.H.

h. Appointment Management.

i. Homemaker Services includes the option for the Acquisition, Maintenance, and Enhancement of Skills (AME) task when the support is related to functional skills training and is desired by the member to accomplish Homemaker tasks to increase their independence and reduce supports needed in the home and community.

i. Detailed, task-related goals shall be documented by case manager in the Person-Centered Support Plan, including documentation monitoring progress and any decrease in human assistance previously authorized.

ii. AME services shall include direct training and instruction to the Member in performing homemaker tasks.

iii. The provider or attendant shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task.

3. All tasks must meet Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older. If additional hours are needed beyond the Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults, Case Managers shall follow the CFC Direct Care Services Exception Request process described in 8.7607.A.

4. Authorization of Homemaker tasks for Members under age 18 must be limited to services that exceed those considered part of Parental or Legal Guardian of a Minor Responsibility as defined in section 8.7502.KK.

8.7527.D Homemaker Services Exclusions and Limitations

1. The CFC Homemaker service may NOT include:

   a. Personal care services.

   b. Services the person can perform independently.

   c. Homemaker services provided in Uncertified Congregate Facilities.

   d. Lawn care, snow removal, routine air duct cleaning, and animal care.

   e. Billing for travel time to and from the Members's home at the beginning and end of the visit is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.

   f. Services that do not meet the task definition for Homemaker.

2. When Homemaker services are provided by a Legally Responsible Person:

   a. A Legally Responsible Person or member of the Member's household may only be paid to furnish Extraordinary Care as defined in Section 8.7502.II.

   b. Members may receive up to 364 hours of Homemaker services annually from a Legally Responsible Person. Additional hours may be authorized when services are provided by a non-Legally Responsible Person.

3. This service is subject to the following Annual CFC Service Soft Caps: Members shall not be authorized for more than 1,125 hours of Homemaker services per Person-Centered Support Plan year. Case Managers may request additional hours through the Department prescribed exception process as defined at Section 8.7607.A.

4. Caregivers must adhere to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

8.7527.E Homemaker Services Provider Agency Requirements

1. All providers shall be certified by the Department as a Homemaker Provider Agency.

2. The Homemaker Provider Agency shall assure and document that all staff receive at least eight hours of training or have passed a skills validation test prior

to providing unsupervised Homemaker services. Training or skills validation shall include:

a. Tasks included in Section 8.7527.C Homemaker Inclusions.

b. Proper food handling and storage techniques.

c. Basic infection control techniques including Universal Precautions.

d. Informing staff of policies concerning emergency procedures.

3. All Homemaker Provider Agency staff shall be supervised by a person who, at a minimum, has received training or passed the skills validation test required of homemakers, as specified above. Supervision shall include, but not be limited to, the following activities:

a. Train staff on Agency policies and procedures.

b. Arrange and document training.

c. Oversee scheduling and notify Members of schedule changes.

d. Conduct supervisory visits to Member's homes at least every three months or more often as necessary for problem resolution, staff skills validation, observation of the home's condition and assessment of Member's satisfaction with services.

i. Supervision should be flexible to the needs of the Member and may be conducted via phone, video conference, telecommunication, or in-person.

1) If there is a safety concern with the services, the Provider Agency must make every effort to conduct an in-person assessment.

2) The Provider Agency must conduct Direct Care Worker (DCW) supervision to ensure that Member care and treatment are delivered in accordance with a plan of care that addresses the Member’s needs.

4. Agencies must ensure that each individual Caregiver adheres to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

8.7527.F Homemaker Provider Services Reimbursement Requirements:

1. Payment for Homemaker Services shall be the lower of the billed charges or the maximum rate of reimbursement set by the Department. Reimbursement shall be per unit of 15 minutes.

2. Payment does not include travel time to or from the Member's residence.

3. If a visit by a home health aide from a Home Health Agency, as defined at Section 8.520.1.L, includes Homemaker Services, only the home health aide visit shall be billed.

4. If a visit by a personal care provider from a personal care Provider Agency, as defined at 8.7001.A.12-B, includes Homemaker Services, the Homemaker Services shall be billed separately from the personal care services.

5. Reimbursement to Legally Responsible Persons for Homemaker services is limited to a maximum of 364 total hours per year, per member.

6. Caregivers must adhere to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

8.7528 In-Home Support Services (IHSS)

8.7528.A In-Home Support Services Eligibility

1. In-Home Support Services (IHSS) is a covered benefit available to Members enrolled in CFC.

8.7528.B In-Home Support Services Definitions

1. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS. A Family Member, including a spouse, may be an Attendant.

2. Authorized Representative means an individual designated by the Member, or by the Parent or Guardian of the Member, if appropriate, who has the judgment and ability to assist the Member in acquiring and receiving services under Title 25.5, Article 6, Part 12, C.R.S. The Authorized Representative shall not be the eligible person's service provider.

3. Care Plan means a written plan of care developed between the Member or the Member's Authorized Representative, In-Home Support Services (IHSS) Agency and Case Management Agency that is authorized by the Case Manager.

4. Intentionally omitted

5. Inappropriate Behavior means documented verbal, sexual, or physical threats or abuse committed by the Member or Authorized Representative toward Attendants, Case Managers, or the In-Home Support Services (IHSS) Agency.

6. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of Institutions. These services include but are not limited to information

and Referral services, independent living skills training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and Institutions to Home and Community-Based living, or upon leaving secondary education.

7. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the Member or Member's Authorized Representative, including Health Maintenance Activities and support for Activities of Daily Living or Instrumental Activities of Daily Living, Personal Care services and Homemaker services.

8. In-Home Support Services (IHSS) Agency means an Agency that is certified by the Colorado Department of Public Health and Environment, enrolled in the Medicaid program and provides Independent Living Core Services.

9. Licensed Health Care Professional means a state-licensed Registered Nurse (RN) who contracts with or is employed by the In-Home Support Services (IHSS) Agency.

8.7528.C In-Home Support Services Member Eligibility

1. To be eligible for In-Home Support Services (IHSS) the Member shall meet the following eligibility criteria:

   a. Be enrolled in CFC.

   b. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition stating that the Member has sound judgment and the ability to self-direct care. If the Member is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.

   c. Members who elect or are required to have an Authorized Representative must appoint an Authorized Representative who has the judgment and ability to assist the Member in acquiring and using services.

   d. Demonstrate a current need for covered Attendant support services.

2. In-Home Support Services (IHSS) eligibility for a Member will end if:

   a. The Member is no longer enrolled in CFC

   b. The Member's medical condition deteriorates causing an unsafe situation for the Member or the Attendant as determined by the Member's Licensed Medical Professional.

c. The Member refuses to designate an Authorized Representative when the Member is unable to direct their own care as documented by the Member's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.

d. The Member provides false information or false records.

e. The Member no longer demonstrates a current need for Attendant support services.

8.7528.D In-Home Support Services (IHSS) Inclusions and Covered Services

1. Services are for the benefit of the Member. Services for the benefit of other persons are not reimbursable.

2. Service Inclusions:

a. Homemaker inclusions are set forth at Section 8.7527.C.

b. Personal Care inclusions are set forth at Section 8.7538.C.

c. Health Maintenance Activities inclusions are set forth at Section 8.7523.C.

8.7528.E In-Home Support Services (IHSS) Exclusions and Limitations

1. In-Home Support Services (IHSS) is a covered benefit for CFC members:

a. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and Prior Authorization Request (PAR) must be submitted and approved by the Case Manager and received by the IHSS Agency prior to services being rendered. Services rendered in advance of approval and receipt of these documents are not reimbursable. All tasks must meet Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older. If additional hours are needed beyond the Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults, Case Managers shall follow the CFC Direct Care Services Exception Request process described in 8.7607.A. Authorization of IHSS tasks must be limited to services that exceed those considered part of Parental or Legal Guardian of a Minor Responsibility as defined at Section 8.7502.KK.

b. Services rendered by an Attendant who shares living space with the Member or Family Members are reimbursable only when the Case Manager determines, prior to the services being rendered, that the services meet the definition of Extraordinary Care as defined at Section 8.7502.II.

c. Health Maintenance Activities may include related Personal Care and/or Homemaker services if such tasks are completed in conjunction with the Health Maintenance Activity and are secondary or contiguous to the Health Maintenance Activity.

i. Secondary means in support of the main task(s). Secondary tasks must be routine and regularly performed in conjunction with a Health Maintenance Activity. The Case Manager must document evidence that the secondary task is necessary for the health and safety of the Member. Secondary tasks do not add units to the care plan.

ii. Contiguous means before, during or after the main task(s). Contiguous tasks must be completed before, during, or after the Health Maintenance Activity. The Case Manager must document evidence that the contiguous task is necessary for the health and safety of the Member. Contiguous tasks do not add units to the care plan.

iii. The IHSS Agency shall not submit claims for Health Maintenance Activities when only Personal Care and/or Homemaking services are completed.

d. Independent Living Core Services, Attendant training, and oversight or supervision provided by the IHSS Agencies Licensed Health Care Professional are not separately reimbursable. No additional compensation is allowable to IHSS Agencies for providing these services.

e. Billing for travel time to and from the Member's home at the beginning and end of the visit is prohibited. Accompaniment of a Member by an Attendant in the community is reimbursable. IHSS Agencies must follow all Department of Labor and Employment guidelines on time worked.

f. Companionship is not a benefit of IHSS and shall not be reimbursed.

2. This service is subject to the following Annual CFC Service Soft Caps: Members shall not be authorized for more than 4,750 hours per PCSP of Health Maintenance Activities, 2,500 hours per PCSP of Personal Care, and/or 1,125 hours per PCSP of Homemaker services. Case Managers may request additional hours through the Department prescribed exception process as defined at Section 8.7607.A.

8.7528.F In-Home Support Services (IHSS) Member and Authorized Representative Participation and Self-Direction

1. A Member or their Authorized Representative may self-direct the following aspects of service delivery:

a. Present a person(s) of their own choosing to the In-Home Support Services (IHSS) Agency as a potential Attendant. The Member must have adequate Attendants to assure compliance with all tasks in the Care Plan.

b. Train Attendant(s) to meet their needs.

c. Dismiss Attendants who are not meeting their needs.

d. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.

e. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the Member's Licensed Medical Professional.

f. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and Referral process.

g. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.

h. Request a Reassessment, as defined at Section 8.7200.B.27, if Level of Care or service needs have changed.

2. An Authorized Representative is not allowed to be reimbursed for In-Home Support Services (IHSS) Attendant services for the Member they represent.

3. If the Member is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:

a. Must be at least 18 years of age.

b. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.

4. The Authorized Representative must attest to the above requirement on the Shared Responsibilities Form.

5. In-Home Support Services (IHSS) Members who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS Member.

6. The Member and their Authorized Representative must adhere to In-Home Support Services (IHSS) Agency policies and procedures.

8.7528.G In-Home Support Services Agency Eligibility

1. The In-Home Support Services (IHSS) Agency must be a licensed home care Agency. The IHSS Agency shall comply with all requirements of their Certification and licensure, in addition to requirements described in Section 8.7400.

2. Administrators or managers as defined at 6 C.C.R. 1011-1 Chapter 26 shall satisfactorily complete the Department authorized training on In-Home Support Services (IHSS) rules and regulations prior to Medicaid Certification and annually thereafter. Provider Agencies must upload the certificate of completion annually into the Medicaid Provider Portal.

8.7528.H In-Home Support Services (IHSS) Agency Responsibilities

1. The In-Home Support Services (IHSS) Agency shall assure and document that all Members are provided the following:

    a. Independent Living Core Services

        i. An IHSS Agency must provide a list of the full scope of Independent Living Core Services provided by the Agency to each Member on an annual basis. The IHSS Agency must keep a record of each Member's choice to utilize or refuse these services, and document services provided.

    b. Attendant training, oversight and supervision by a licensed healthcare professional.

    c. The IHSS Agency shall provide 24-hour back-up service for scheduled visits to Members at any time an Attendant is not available. At the time the Care Plan is developed the IHSS Agency shall ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.

2. The In-Home Support Services (IHSS) Agency shall adhere to the following:

    a. If the IHSS Agency admits Members with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the Agency or have other effective back-up plans to ensure the needs of the Member are met.

    b. The IHSS Agency shall only accept Members for care or services based on a reasonable assurance that the needs of the Member can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.

        i. There shall be documentation in the Care Plan or Member record of the agreed upon days and times of services to be provided based upon the Member's needs that is updated at least annually.

c. If an IHSS Agency receives a Referral of a Member who requires care or services that are not available at the time of Referral, the IHSS Agency shall advise the Member or their Authorized Representative and the Case Manager of that fact.

i. The IHSS Agency shall only admit the Member if the Member or their Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.

d. The IHSS Agency shall ensure orientation is provided to Members or Authorized Representatives who are new to IHSS or request re-orientation through the Department's prescribed process. Orientation shall include instruction in the philosophy, policies, and procedures of IHSS and information concerning Member rights and responsibilities.

e. The IHSS Agency will keep written service notes documenting the services provided at each visit.

3. The In-Home Support Services (IHSS) Agency is the legal employer of a Member's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by the Department.

4. IHSS Agencies must ensure that each individual Attendant adheres to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

5. The In-Home Support Services (IHSS) Agency shall assist all Members in interviewing and selecting an Attendant when requested and maintain documentation of the IHSS Agency's assistance and/or the Member's refusal of such assistance.

6. The In-Home Support Services (IHSS) Agency will complete an intake Assessment following Referral from the Case Manager. Utilizing the authorized units provided on the IHSS Care Plan Calculator provided by the Case Manager, the IHSS Agency will develop a Care Plan in coordination with the Case Manager and Member. Any proposed services described in the Care Plan that differ from the authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to the start of services.

7. The In-Home Support Services (IHSS) Agency shall ensure that a current Care Plan is in the Member's record, and that Care Plans are updated with the Member at least annually or more frequently in the event of a Member's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.

a. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope, and duration of each service to be provided to the Member for each day and visit. The Care Plan shall be

signed by the Member or the Member's Authorized Representative and the IHSS Agency.

i. Secondary or contiguous tasks must be described on the care plan as required in Section 8.7528.E.3.a-b.

b. In the event of the observation of new symptoms or worsening condition that may impair the Member's ability to direct their care, the IHSS Agency, in consultation with the Member or their Authorized Representative and Case Manager, shall contact the Member's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the Member's revised Care Plan, with the Member and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval.

8. The In-Home Support Services (IHSS) Agencies Licensed Health Care Professional is responsible for the following activities:

a. Administer a skills validation test for Attendants who will perform Health Maintenance Activities. Skills validation for all assigned tasks must be completed prior to service delivery unless postponed by the Member or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS Agency in the Member's file. In no event shall the skills validation be postponed for more than thirty (30) days after services begin to prevent interruption in services.

b. Verify and document Attendant skills and competency to perform IHSS and basic Member safety procedures.

c. Counsel Attendants and staff on difficult cases and potentially dangerous situations.

d. Consult with the Member, Authorized Representative or Attendant in the event a medical issue arises.

e. Investigate Complaints and Incidents within ten (10) calendar days as required in Section 8.7411.

f. Verify the Attendant follows all tasks set forth in the Care Plan.

g. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the Member, their Authorized Representative, or the Case Manager.

h. Provide in-home supervision for the Member as recommended by their Licensed Medical Professional and as agreed upon by the Member or their Authorized Representative.

9. At the time of enrollment and following any change of condition, the In-Home Support Services (IHSS) Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the Member record.

   a. The IHSS Agency shall collaborate with the Member or Member's Authorized Representative to determine the level of supervision provided by the IHSS Agency's Licensed Health Care Professional beyond the requirements set forth at Section 25.5-6-1203, C.R.S.

   b. The Member may decline recommendations by the Licensed Medical Professional for in-home supervision. The IHSS Agency must document this choice in the Member record and notify the Case Manager. The IHSS Agency and their Licensed Health Care Professional, Case Manager, and Member or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

10. The In-Home Support Services (IHSS) Agency shall assure and document that all Attendants have received training in the delivery of IHSS prior to the start of services. Attendant training shall include:

    a. Development of interpersonal skills focused on addressing the needs of persons with disabilities.

    b. Overview of IHSS as a service-delivery option of consumer direction.

    c. Instruction on basic first aid administration.

    d. Instruction on safety and emergency procedures.

    e. Instruction on infection control techniques, including Universal Precautions.

    f. Mandatory reporting and Incident reporting procedures.

    g. Skills validation test for unskilled tasks assigned on the care plan.

10. The In-Home Support Services (IHSS) Agency shall allow the Member or Authorized Representative to provide individualized Attendant training that is specific to their own needs and preferences.

11. With the support of the In-Home Support Services (IHSS) Agency, Attendants must adhere to the following:

    a. Must be at least 16 years of age and demonstrate competency in caring for the Member to the satisfaction of the Member or Authorized Representative.

        i. Minor attendants ages 16 to 17 will not be permitted to operate floor-based vertical powered patient/resident lift devices, ceiling-mounted vertical powered patient/resident lift devices, and powered sit-to-stand patient/resident lift devices (lifting devices).

    b. May be a Family Member subject to the reimbursement and service limitations in 8.7528.J.

    c. Must be able to perform the assigned tasks on the Care Plan.

    d. Shall not, in exercising their duties as an In-Home Support Services (IHSS) Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse pursuant to Section 25.5-6-1203(3), C.R.S.

    e. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.

12. The In-Home Support Services (IHSS) Agency shall provide functional skills training to assist Members and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

8.7528.I In-Home Support Services (IHSS) Case Management Agency Responsibilities

1. The Case Manager shall provide information and resources about In-Home Support Services (IHSS) to eligible Members, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.

2. The Case Manager will initiate a Referral to the In-Home Support Services (IHSS) Agency of the Member or Authorized Representative's choice, including an outline of approved services as determined by the Case Manager's most recent Assessment. The Referral must include the Physician Attestation, Assessment information, and other pertinent documentation to support the development of the Care Plan.

3. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:

    a. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.

    b. The Shared Responsibilities Form shall be completed upon enrollment and following any change of condition. If the Member requires an Authorized Representative, the Shared Responsibilities Form must include the designation and attestation of an Authorized Representative.

4. Upon the receipt of the Care Plan, the Case Manager shall:

    a. Review the Care Plan within five business days of receipt to ensure there is no disruption or delay in the start of services.

    b. Ensure all required information is in the Member's Care Plan and that services are appropriate given the Member's medical or functional condition. If needed, request additional information from the Member, their Authorized Representative, the In-Home Support Services (IHSS) Agency, or Licensed Medical Professional regarding services requested.

    c. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.

    d. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the Member's eligible benefits.

    e. Collaborate with the Member or their Authorized Representative and the In-Home Support Services (IHSS) Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.

    f. Authorize cost-effective and non-duplicative services via the Prior Authorization Request (PAR). Provide a copy of the Prior Authorization Request (PAR) to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.

    g. Work collaboratively with the IHSS Agency, Member, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.

        i. Case Managers will complete the Long-Term Care Program Notice of Action (LTC-803) and provide the Member or the Authorized Representative with the reasons for denial of requested service

frequency or duration, information about the Member's rights to fair hearing, and appeal procedures.

5. The Case Manager shall ensure cost-effectiveness and non-duplication of services by:

    a. Documenting the discontinuation of previously authorized Agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by In-Home Support Services (IHSS).

    b. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.

        i. A Member may receive non-duplicative services from multiple Attendants or agencies if appropriate for the Member's Level of Care and documented service needs.

    c. Ensuring the Member's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan and requesting additional information as needed.

    d. Coordinating transitions from a hospital, nursing facility, or other Agency to IHSS. Assisting Members with transitions from IHSS to alternate services if appropriate.

    e. Collaborating with the Member or their Authorized Representative and the IHSS Agency in the event of any change in condition. The Case Manager shall request an updated Physician Attestation of Consumer Capacity form. The Case Manager may revise the Care Plan as appropriate given the Member's condition and functioning.

    f. Completing a Reassessment as defined at Section 8.7200.B.27 if requested by the Member if Level of Care or service needs have changed.

6. The Case Manager shall not authorize more than one consumer-directed program on the Member's Prior Authorization Request (PAR).

7. The Case Manager shall participate in training and consultative opportunities with the Department's Consumer-Directed Training and Support Contractor.

8. Additional requirements for Case Managers:

    a. Contact the Member or Authorized Representative once a month during the first three months of receiving In-Home Support Services (IHSS) to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.

b. Contact the Member or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.

c. Contact the Member or Authorized Representative when a change in Authorized Representative occurs and continue contact once a month for three months after the change takes place.

d. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the Agency, and supervision provided. The Case Manager must document and keep record of the following:

i. In-Home Support Services (IHSS) Care Plans;

ii. In-home supervision needs as recommended by the Physician;

iii. Independent Living Core Services offered and provided by the IHSS Agency; and

iv. Additional supports provided to the Member by the IHSS Agency.

9. Start of Services

a. Services may begin only after the requirements of Sections 8.7528.C, 8.7528.H.5, 8.7528.H.9, and 8.7528.I.3 of this rule have been met.

b. The Case Manager shall follow the Department's assessment process and receive authorization prior to authorizing a start date for Attendant services for Person-Centered Support Plans that;

i. Contain Health Maintenance Activities; or

ii. Exceed the cost of care received in an institutional setting.

c. The Case Manager shall establish a service period and submit a Prior Authorization Request (PAR), providing a copy to the In-Home Support Services (IHSS) Agency prior to the start of services.

10. Case Managers must follow the Weekly Caregiver Limit Exception Request processes described in Section 8.7419.

8.7528.J In-Home Support Services (IHSS) Reimbursement and Service Limitations

1. In-Home Support Services (IHSS) Personal Care services must comply with the rules for reimbursement set forth at Section 8.7538 Personal Care. IHSS

Homemaker services must comply with the rules for reimbursement set forth at Section 8.7527 Homemaker Services.

2. The In-Home Support Services (IHSS) Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved Prior Authorization Request (PAR). The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.

3. The In-Home Support Services (IHSS) Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.

4. Services by an Authorized Representative to represent the Member are not reimbursable. In-Home Support Services (IHSS) services performed by an Authorized Representative for the Member that they represent are not reimbursable.

5. IHSS Agencies must ensure that Attendants adhere to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

6. A Member cannot receive In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS) at the same time.

7. Reimbursement to Legally Responsible Persons for Homemaker services is limited to a maximum of 364 total hours per year, per member.

8. Payment does not include travel time to or from the Member's residence.

8.7528.K In-Home Support Services (IHSS) Discontinuation and Termination

1. A Member may elect to discontinue In-Home Support Services (IHSS) or use an alternate service-delivery option at any time.

2. A Member may be discontinued from In-Home Support Services (IHSS) when equivalent care in the community has been secured.

3. The Case Manager may terminate a Member’s participation in In-Home Support Services (IHSS) for the following reasons:

    a. The Member or their Authorized Representative fails to comply with IHSS program requirements as defined in Section 8.7528.F, or

    b. A Member no longer meets program criteria, or

c. The Member provides false information, false records, or is convicted of fraud, or

d. The Member or their Authorized Representative exhibits Inappropriate Behavior, and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.

i. The IHSS Agency and Case Manager are required to assist the Member or their Authorized Representative to resolve the Inappropriate Behavior, which may include the addition of or a change of Authorized Representative. All attempts to resolve the Inappropriate Behavior must be documented prior to notice of termination.

4. When an In-Home Support Services (IHSS) Agency discontinues services, the Agency shall give the Member and the Member's Authorized Representative written notice of at least thirty days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice shall be considered given when it is documented that the Member or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the Case Management Agency.

a. Exceptions will be made to the requirement for advanced notice when the In-Home Support Services (IHSS) Agency has documented that there is an immediate threat to the Member, IHSS Agency, or Attendants.

b. Upon In-Home Support Services (IHSS) Agency discretion, the Agency may allow the Member or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

5. If continued services are needed with another Agency, the current In-Home Support Services (IHSS) Agency shall collaborate with the Case Manager and Member or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the Member’s safety and welfare.

6. In the event of discontinuation or termination from In-Home Support Services (IHSS), the Case Manager shall:

a. Complete the Long-Term Care Program Notice of (LTC-803) and provide the Member or the Authorized Representative with the reasons for termination, information about the Member’s rights to fair hearing, and appeal procedures. Once notice has been given, the Member or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.

8.7529 Independent Living Skills Training

8.7529.A Independent Living Skills Training Eligibility

1. Independent Living Skills Training is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.7529.B Independent Living Skills Training Descriptions and Definitions

1. Independent Living Skills Training (ILST) means services designed and developed based on the Member's ability to independently sustain themselves physically, emotionally, and economically in the community. ILST may be provided in the Member's residence or in the community.

2. ILST Care Plan means a person-centered plan that describes the ILST services necessary to enable the Member to independently sustain themselves physically, emotionally, and economically in the community. This plan is developed with the Member and the Provider Agency.

3. ILST Trainers are individuals trained in accordance with guidelines listed below and tasked with providing the service to the Member.

8.7529.C Independent Living Skills Training Inclusions

1. Reimbursable services are limited to the assessment, training, maintenance, supervision, assistance, or continued supports of the following skills:

    a. Self-care, including but not limited to basic personal hygiene;

    b. Medication supervision and reminders;

    c. Household management;

    d. Time management skills training;

    e. Safety awareness skill development and training;

    f. Task completion skill development and training;

    g. Communication skill building;

    h. Interpersonal skill development;

    i. Socialization, including but not limited to acquiring and developing appropriate social norms, values, and skills;

    j. Recreation, including leisure and community integration activities;

    k. Sensory motor skill development;

l. Benefits coordination, including activities related to the coordination of Medicaid services;

m. Resource coordination, including activities related to coordination of community transportation, community meetings, neighborhood resources, and other available public and private resources;

n. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting.

2. All ILST shall be documented in the ILST Care Plan. Reimbursement is limited to services described in the ILST Care Plan.

8.7529.D Independent Living Skills Exclusions and Limitations

1. Members who reside in a Supportive Living Program (SLP) as defined in Section 8.7550 are not eligible for Independent Living Skills services.

2. Travel to and from the Member's home is not reimbursable.

8.7529.E Independent Living Skills Training Provider Agency Requirements

1. Provider Agencies must have valid licensure and certification as well as appropriate professional oversight.

a. Agencies seeking to provide ILST services must have a valid Home Care Agency Class A or B license or an Assisted Living Residency license and Transitional Living Program Certification from the Department of Public Health and Environment.

b. Agencies must employ an ILST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, Brain Injury, and a degree within a relevant field.

i. This coordinator must review ILST Care Plans to ensure Member plans are designed and directed at the development and maintenance of the Member's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

c. Any component of the ILST Care Plan that may contain activities outside the scope of the ILST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the Member. These professionals must hold licenses with no limitations in one of the following professions:

i. Occupational Therapist;

ii. Physical Therapist;

iii. Registered Nurse;

iv. Speech Language Pathologist;

v. Psychologist;

vi. Neuropsychologist;

vii. Medical Doctor;

viii. Licensed Clinical Social Worker;

ix. Licensed Professional Counselor.

d. Professionals providing components of the ILST Care Plan may include individuals who are Members of Provider Agency staff, contracted staff, or external licensed and certified professionals who are fully aware of duties conducted by ILST trainers.

e. All ILST Care Plan containing any professional activity must be reviewed and authorized at least every 6 months, or as needed, by professionals responsible for oversight as referenced in 8.7529.E.1.c.i-iii

2. ILST trainers must meet one of the following education, experience, or certification requirements:

a. Licensed health care professionals with experience in providing functionally based assessments and skills training for individuals with disabilities; or

b. Individuals with a bachelor's degree and one (1) year of experience working with individuals with disabilities; or

c. Individuals with an associate degree in a social service or human relations area and two (2) years of experience working with individuals with disabilities; or

d. Individuals currently enrolled in a special education, occupational therapy, therapeutic recreation, and/or teaching degree program with at least three (3) years of experience providing services similar to ILST services; or

e. Individuals with four (4) years direct care experience teaching or working with individuals with a Brain Injury or other cognitive disability either in a home setting, hospital setting, or rehabilitation setting.

3. The Provider Agency shall administer a series of training programs to all ILST trainers.

a. Prior to delivery of and reimbursement for services, ILST trainers must complete the following trainings:

i. Person-centered care approaches;

ii. HIPAA and Member confidentiality;

iii. Basics of Brain Injury including at a minimum:

1) Basic neurophysiology;

2) Impact of a Brain Injury on an individual;

3) Epidemiology of Brain Injury;

4) Common physical, behavioral, and cognitive impairments and interactions strategies;

5) Best practices in Brain Injury recovery; and

6) Screening for a history of Brain Injury.

iv. On-the-job coaching by an incumbent ILST trainer;

v. Basic safety and de-escalation techniques;

vi. Training on community and public resource availability;

vii. Understanding of current brain injury recovery guidelines; and

viii. First aid.

b. ILST trainers must also receive ongoing training, required annually, in the following areas:

i. Cultural awareness;

ii. Updates on Brain Injury recovery guidelines; and

iii. Updates on resource availability.

8.7529.F Independent Living Skills Training Provider Agency Reimbursement

1. ILST shall be reimbursed according to the number of units billed, with one (1) unit equal to fifteen (15) minutes of service. Payment and billing may not include travel time to and from the Member's residence.

8.7530 Life Skills Training

8.7530.A Life Skills Training Eligibility

1. Life Skills Training is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Community Mental Health Supports Waiver

    b. Complementary and Integrative Health Waiver

    c. Elderly, Blind, and Disabled Waiver

    d. Supported Living Services Waiver

8.7530.B Life Skills Training Definitions

1. Life Skills Training means individualized training designed and directed with the Member to develop and maintain their ability to independently sustain themselves physically, emotionally, socially and economically in the community.

2. Life Skills Training Trainer means the person(s) that directly supports the Member by designing with the Member an individualized LST service plan. Trainers implement the plan to develop and maintain the Members' ability to independently sustain themselves physically, emotionally, socially and economically in the community.

3. The LST coordinator means the person that reviews the Member's LST service plan to ensure it is designed to meet the needs of the Member in order to enable them to independently sustain themselves physically, emotionally, and economically in the community.

8.7530.C Life Skills Training Inclusions

1. HCBS Elderly, Blind, and Disabled (EBD) Waiver; Community Mental Health Supports (CMHS) Waiver; Complementary and Integrative Health (CIH) Waiver; Supported Living Services (SLS) Waiver

2. Life Skills Training includes Assessment, training, maintenance, supervision, assistance, or continued supports of the following skills:

    a. Problem-solving;

    b. Identifying and accessing mental and behavioral health services;

    c. Self-care and Activities of Daily Living;

    d. Medication reminders and supervision, not including medication administration;

e. Household management;

f. Time management;

g. Safety awareness;

h. Task completion;

i. Communication skill building;

j. Interpersonal skill development;

k. Socialization, including, but not limited to: acquiring and developing skills that promote healthy relationships, assistance with understanding social norms and values, and support with acclimating to the community;

l. Recreation, including leisure and community engagement;

m. Assistance with understanding and following plans for occupational or sensory skill development;

n. Accessing resources and benefit coordination, including activities related to coordination of community transportation, community meetings, community resources, housing resources, Medicaid services, and other available public and private resources;

o. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting; and

p. Acquiring and utilizing assistive technology when appropriate and not duplicative of training covered under other services.

q. Life Skills Training (LST) may be provided in the Member's residence or in the community.

8.7530.D Life Skills Training Service Access and Authorization

1. To obtain approval for Life Skills Training, the Member must demonstrate a need for the service as follows:

   a. The Member demonstrates a need for training designed and directed to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community;

   b. The Member identifies skills for which training is needed and demonstrates that without the skills, the Member risks their health, safety, or ability to live in the community;

c. The Member demonstrates that without training they could not develop the skills needed; and

d. The Member demonstrates that with training they have the ability to acquire these skills or services necessary within 365 days.

2. To establish eligibility for Life Skills Training, the Member must satisfy general criteria for accessing the service:

a. The Member is transitioning from an institutional setting to a Home and Community-Based setting, or is experiencing a qualifying change in life circumstance that affects a Member's stability and endangers their ability to remain in the community;

b. The Member demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and

c. The Member demonstrates that they need the service to establish community support or resources where they may not otherwise exist.

8.7530.E Life Skills Training Service Requirements

1. The Member's Case Manager must not authorize Life Skills Training for more than 365 days. The Department, in its sole discretion, may grant an exception based on extraordinary circumstances.

2. The LST coordinator must share the LST CarePlan 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 Care Plan, or any portion of it, with other providers; and

3. Any component of the LST Care Plan that may contain activities outside the scope of the LST trainer's scope of expertise or licensure must be created by the appropriately licensed professional within his/her scope of practice.

4. All LST Care Plans containing any professional activity must be reviewed and authorized monthly during the service period, or as needed, by professionals responsible for oversight.

5. All LST Provider Agencies must maintain a LST CarePlan that includes:

a. Monthly skills training plans to be developed and documented;

b. Skills training plans that include goals, goals achieved or failed, and progress made toward accomplishment of continuing goals;

c. The start and end time/duration of service provision;

d. The nature and extent of service;

e. A description of LST activities;

f. Progress toward Care Plan goals and objectives; and

g. The provider's signature and date.

6. The LST Care Plan shall be sent to the Case Management Agency responsible for the Person-Centered Support Plan on a quarterly basis, or as requested by the Case Management Agency.

7. The LST Care Plan shall be shared, with the Member's permission, with the Member's other HCBS Provider Agencies.

8.7530.F Life Skills Training Service Exclusions and Limitations

1. Members may utilize LST up to 24 units (six hours) per day, for no more than 160 units (40 hours) per week, for no more than 365 days following the first day the service is provided.

2. LST is not to be delivered simultaneously during the direct provision of Adult Day Services, Group Behavioral Counseling, Consumer Directed Attendant Support Services (CDASS), Health Maintenance Activities, Homemaker, In-Home Support Services (IHSS), Mentorship, Peer Mentorship, Personal Care, Prevocational Services, Respite, Specialized Habilitation, Supported Community Connections, or Supported Employment.

   a. LST services may be provided in conjunction with Non-Medical Transportation if it is described in the Member's LST Care Plan. Services are billable only when provided by an enrolled NMT Provider Agency, who is not the LST Provider Agency.

3. LST does not include services offered through State Plan or other Waiver Services, except those that are incidental to the LST training activities or purposes or are incidentally provided to ensure the Member's health and safety during the provision of LST.

8.7530.G Life Skills Training Service Provider Agency Requirements

1. The Provider Agency must employ an LST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, or a degree within a relevant field; and

2. The Provider Agency must ensure any component of the LST plan that may contain activities outside the scope of the LST trainer's expertise or licensure must be created by an appropriately licensed professional acting within his/her scope of practice.

a. The professional must hold a license with no limitations in the scope of practice appropriate to meet the Member's LST needs. The following licensed professionals are authorized to furnish LST training:

i. Occupational Therapist;

ii. Physical Therapist;

iii. Registered Nurse;

iv. Speech Language Pathologist;

v. Psychologist;

vi. Neuropsychologist;

vii. Medical Doctor;

viii. Licensed Clinical Social Worker

ix. Licensed Professional Counselor; or

x. Board Certified Behavior Analyst (BCBA).

b. An appropriately licensed professional providing a component(s) of the LST Care Plan may be a Provider Agency staff member, contract staff member, or external licensed and certified professionals who are fully aware of duties conducted by LST trainers.

3. A Provider Agency must maintain a Class A or B Home Care Agency License issued by the Colorado Department of Public Health and Environment if that Agency chooses to provide training on Personal Care as defined at Section 8.7538

4. The Provider Agency must employ one or more LST Trainers to directly support Members, one-on-one, by designing with the Member their LST care plan and implementing the plan for the Member's training.

a. An individual is qualified to be an LST trainer only if they are:

i. A licensed healthcare professional with experience in providing functionally based assessments and skills training for individuals with disabilities;

ii. An individual with a bachelor's degree and one (1) year of experience working with individuals with disabilities;

iii. An individual with an associate's degree in a social service or human relations area and two (2) years of experience working with individuals with disabilities;

iv. An individual currently enrolled in a degree program related directly to special education, occupational therapy, therapeutic recreation, and/or teaching with at least three (3) years of experience providing services similar to LST services;

v. An individual with four (4) years direct care experience teaching or working with needs of individuals with disabilities; or

vi. An individual with four (4) years of lived experience transferable to training designed and directed with the Member to develop and maintain their ability to sustain himself/herself physically, emotionally, socially and economically in the community. The Provider Agency must ensure that this individual receives Member-specific training sufficient to enable the individual to competently provide LST to the Member consistent with the LST care plan.

b. Prior to delivery of and reimbursement for any services, LST trainers must complete the following trainings:

i. Person-centered support approaches;

ii. HIPAA and Member's confidentiality;

iii. Basics of working with the population to be served;

iv. On-the-job coaching by the provider or an incumbent LST trainer on the provision of LST training;

v. Basic safety and de-escalation techniques;

vi. Community and public resource availability; and

vii. Recognizing emergencies and knowledge of emergency procedures including basic first aid, home and fire safety.

c. The Provider Agency must ensure that staff acting as LST trainers receive ongoing training within 90 days of unsupervised contact with a Member, and no less than once annually, in the following areas:

i. Cultural awareness;

ii. Updates on working with the population to be served; and

iii. Updates on resource availability.

8.7530.H Life Skills Training Service Provider Agency Reimbursement

1. LST may be billed in 15-minute units. Members may utilize LST up to 24 units (six hours) per day, no more than 160 units (40 hours) per week, for up to 365 days following the first day the service is provided.

2. Payment for LST shall be the lower of the billed charges or the maximum rate of reimbursement.

3. LST may include escorting Members if doing so is incidental to performing an authorized LST service. However, costs for transportation in addition to those for accompaniment may not be billed LST services. If accompaniment and transportation are provided through the same Agency, the person providing transportation may not be the same person who provided accompaniment as a LST benefit to the Member.

8.7531 Massage Therapy

8.7531.A Massage Therapy Eligibility

1. Massage Therapy is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Children with Complex Health Needs Waiver

    b. Children’s Extensive Support Waiver

    c. Children's Habilitation Residential Program

    d. Complementary and Integrative Health Waiver

    e. Supported Living Services Waiver

8.7531.B Massage Therapy Definition

1. Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and psychological changes.

8.7531.C Massage Therapy Inclusions

1. Massage therapy shall only be used for the treatment of conditions related to the Member’s illness, medical need, or behavioral need as identified on the Person-Centered Support Plan.

2. Massage therapy includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension, and WATSU.

3. Massage Therapy shall be provided in a licensed massage therapist's office, an approved outpatient setting, or in the Member's residence.

4. HCBS Complementary and Integrative Health Waiver (CIH); Support Living Services (SLS)

    a. Members receiving massage therapy services may be asked to participate in an independent evaluation to determine the effectiveness of the services.

8.7531.D Massage Therapy Exclusions and Limitations

1. Massage therapy is not available if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.

2. HCBS Support Living Services (SLS) Waiver; Children's Extensive Services (CES) Waiver; Children with Complex Health Needs (CwCHN) Waiver; Children's Habilitation Residential Program (CHRP) Waiver:

    a. The following items are excluded and are not eligible for reimbursement:

        i. Acupuncture;

        ii. Chiropractic care; and

        iii. Experimental treatments or therapies.

3. Massage Therapy Service Limitations:

    a. HCBS Children with Complex Health Needs Waiver:

        i. Massage Therapy shall be limited to the Member's assessed need up to a maximum of 24 hours per annual certification period.

    b. HCBS Complementary and Integrative Health Waiver:

        i. A maximum of 408 combined units of Acupuncture, Chiropractic, and Massage Therapy Waiver Services may be covered as a benefit during the support plan year.

8.7531.E Massage Therapy Provider Agency Requirements

1. Massage Therapy providers shall be licensed and in good standing pursuant to § 12-235-101, et seq., (C.R.S.)

2. HCBS Supported Living Services (SLS) Waiver, HCBS Children's Extensive Services (CES) Waiver; Children's Habilitation Residential Program (CHRP) Waiver:

a. The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

3. HCBS Complementary and Integrative Health Waiver

a. Massage Therapy providers shall have at least year of experience practicing Massage Therapy at a rate of 520 hours per year; OR year of experience working with individuals with paralysis or other long term physical disabilities.

b. Massage Therapy Provider Agencies shall:

i. Determine the appropriate modality, amount, scope, and duration of the massage therapy service within the established limits at Section 8.7531.D.3.2.a.

ii. Recommend only services that are necessary and appropriate in a care plan.

iii. Provide only services in accordance with the Member's prior authorized units.

8.7532 Mental Health Transitional Living Homes

8.7532.A Mental Health Transitional Living Homes Definitions

1. Mental Health Transitional Living Home (MHTL) Endorsement means documentation from the Behavioral Health Administration (BHA) recommending endorsement to the Department after the Provider Agency has met all licensing and regulatory requirements of the BHA and is licensed as a Mental Health Transitional Living Home.

2. Protective Oversight is as defined at Section 8.7506.B.2.

8.7532.B Mental Health Transitional Living Homes Member Eligibility

1. Mental Health Transitional Living Homes (MHTL) service is a covered benefit available to Members who meet the following requirements:

a. Members are determined functionally eligible for Community Mental Health Supports (CMHS) waiver by a Case Management Agency;

b. Members are enrolled in the HCBS Community Mental Health Supports Waiver; and

c. Members require the specialized services provided under the Mental Health Transitional Living Homes as determined by assessed need.

8.7532.C Mental Health Transitional Living Homes Inclusions

1. The Mental Health Transitional Living service assists the Member to reside in the most integrated setting appropriate to their needs. Staff shall be specifically trained to support Members with a severe and persistent mental illness and who may be experiencing a mental health crisis or episode.

2. This residential service includes the following:

    a. Protective Oversight and supervision as defined at Section 8.7506.B.2.;

    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 as defined at 8.7530.B; and

    g. Activities of Daily Living support as needed.

3. Room and board are not benefits of Mental Health Transitional Living services. Members are responsible for room and board in an amount not to exceed the Department's established rate.

4. Additional services that are available as a State Plan benefit or other HCBS Community Mental Health Supports Waiver service shall not be provided under the Mental Health Transitional Living service.

5. Member engagement opportunities shall be provided by the Mental Health Transitional Living home as outlined in 8.7001.

8.7532.D Mental Health Transitional Living Homes Member Rights

1. Mental Health Transitional Living Homes shall inform Members of their rights, according to Section 8.7001. Any modification of those rights shall be in accordance with Section 8.7001.B.4. , Mental Health Transitional Living Homes shall ensure the policy on resident rights is posted in a visible location so that it is always available to Members and visitors.

2. Mental Health Transitional Living Homes shall inform Members of all policies specific to the Mental Health Transitional Living setting upon admission to the setting, and when changes to policies are made, rules and/or policies shall apply consistently to the administrator, staff, volunteers, and Members residing in the

home and their family or friends who visit. Member acknowledgement of rules and policies must be documented in the service plan or a resident agreement.

3. If requested by the Member, the Mental Health Transitional Living home shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal possessions.

8.7532.E Mental Health Transitional Living Provider Agency Eligibility

1.

2. Applicants for Mental Health Transitional Living Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by the Colorado Division of Fire Prevention and Control.

3. Mental Health Transitional Living Provider Agencies must receive from the BHA a BHE license and MHTL endorsement.

4. No recommendation for Mental Health Transitional Living Certification shall be issued if the owner, applicant, or administrator of the Mental Health Transitional Living home has been convicted of a felony or misdemeanor involving a crime of moral turpitude or that involves conduct that the Department determines could pose a risk to the health, safety, or welfare of the members residing in the Mental Health Transitional Living home.

5. Provider Agencies must be certified and enrolled with the Department prior to rendering services.

6.

8.7532.F Mental Health Transitional Living Provider Agency Roles and Responsibilities

1. Service Requirements

   a. The Mental Health Transitional Living Provider Agencies shall provide Protective Oversight and Mental Health Transitional Living services to Members every day of the year, 24 hours per day.

b. Mental Health Transitional Living Provider Agencies shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 CCR 1011-1, Chapter XXIV (2025) which is hereby incorporated by reference. Such incorporation excludes later amendments to or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E. 17th Ave, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at https://www.sos.state.co.us/CCR/DisplayRule.do?action=ruleinfo&ruleId=3052&deptID=16&agencyID=144&deptName=Department%20of%20Public%20Health%20and%20Environment&agencyName=Health%20Facilities%20and%20Emergency%20Medical%20Services%20Division%20(1011,%201015%20Series)&seriesNum=6%20CCR%201011-1%20Chapter%2026}

c. Mental Health Transitional Living Provider Agencies shall not discontinue services to a Member unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services in accordance with Section 8.7001.B. 4.

d. The Provider Agency shall encourage and assist Members' participation in engagement opportunities and activities within the Mental Health Transitional Living home community and the wider community, when appropriate.

e. The Provider Agency shall develop emergency policies that address, at a minimum, a plan that ensures the availability of, or access to, emergency power for essential functions and all member-required medical devices or auxiliary aids.

2. Provider Agency Service Plan

a. The service plan must outline the goals, choices, preferences, and needs of the Member. Medical information must also be included, specifically:

i. If the Member is taking any medications and how they are administered, with reference to the Medication Administration Record (MAR);

ii. Supports needed with Activities of Daily Living;

iii. Special dietary needs, if any; and

iv. Incorporation of any documented physician orders.

b. Even if recommended by the Member's physician or other practitioner, staff interventions that interfere with the Member's choice of food, freedom to determine their own activities, or exercise of any other rights are Rights Modifications that must comply with Section 8.7001.B.

c. The service plan must contain evidence that the Member and/or their Guardian or other Legally Authorized Representative has had the opportunity to participate in the development of the plan, as evidenced by the Member's and/or their Guardian's or other Legally Authorized Representative's signature on the plan. The signature may be physical or digital that includes a date and time stamp. If the Member is unable to sign the service plan because of a medical condition, any mark the Member is capable of making shall be accepted in lieu of a signature. If the Member is not capable of making a mark or performing a digital signature, the physical or digital signature of a Guardian or other Legally Authorized Representative shall be accepted.

3. Environmental Standards

a. The Mental Health Transitional Living Provider Agency shall adhere to regulations established by the BHA in sections 2.6 and 2.26 of 2 CCR 502-1 (2025) which is hereby incorporated by reference. Such incorporation excludes later amendments to or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E. 17th Ave, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at [https://www.sos.state.co.us/CCR/DisplayRule.do?action=ruleinfo&ruleId=2157&deptID=9&agencyID=70&deptName=Department%20of%20Human%20Services&agencyName=Behavioral%20Health&seriesNum=2%20CCR%20502-1}

4. Staffing

a. The Mental Health Transitional Living home must have appropriate staffing levels to meet the individual acuity, needs and level of assistance required of the Members in the setting.

b. Staff must be trained to meet the following requirements under 2 CCR 502-1 (including those applicable to general behavioral health entity (BHE) and any additional requirements applicable to MHTLs) and for certification under Section 8.7400 prior to working independently with Members:

i. Training specific to the particular needs of the populations served, including the provision of person-centered, trauma-informed, harm reduction-focused, physically and programmatically accessible, and culturally and linguistically responsive services;

ii. Infection Control;

iii. Emergency preparedness, including de-escalation of potentially dangerous situations, including but not limited to threats of violence, acts of violence, and abuse/mistreatment of an individual;

iv. Critical Incident Reporting;

v. Suicide prevention;

vi. Individual rights of the population served;

vii. Confidentiality, including individual privacy and records privacy and security;

viii. BHE policies and procedures;

ix. Mandatory reporting requirements for suspected abuse or neglect in accordance with 2 CCR 502-1 §(2)(A) and Section 8.7411 (2025). 2 CCR 502-1 § (2)(A) (2025) hereby incorporated by reference. Such incorporation excludes later amendments to or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E. 17th Ave, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at [https://www.sos.state.co.us/CCR/DisplayRule.do?action=ruleinfo&ruleId=2157&deptID=9&agencyID=70&deptName=Department%20of%20Human%20Services&agencyName=Behavioral%20Health&seriesNum=2%20CCR%20502-1}; and

x. Understanding of basic pharmacology and medications that are relevant to the treatment type and population served by the agency, including but not limited to medication-assisted treatment (MAT) services and medications for opioid use disorders (MOUD).

8.7532.G Mental Health Transitional Living Homes Reimbursement

1. Mental Health Transitional Living services are reimbursed on a per diem basis, as determined by the Department.

2. Additional Charges

    a. Provider Agencies shall not bill supplemental charges to any Members, except for amounts designated as copayments by the Department.

8.7533 Mentorship

8.7533.A Mentorship Eligibility

1. Mentorship is a covered benefit available to Members enrolled in the HCBS Supported Living Services Waiver.

8.7533.B Mentorship Definition

1. Mentorship means services that are provided to Members to promote self-advocacy through methods such as instructing, providing experiences, modeling, and advising.

8.7533.C Mentorship Inclusions

1. Assistance in interviewing potential providers.

2. Assistance in understanding complicated health and safety issues.

3. Assistance with participation on private and public boards, advisory groups, and commissions.

4. Training in child and infant care for Members who are parenting children.

8.7533.D Mentorship Exclusions and Limitations

1. Mentorship services shall not duplicate Case Management or other HCBS-SLS Waiver Services.

2. Mentorship services are limited to 192 units (48 hours) per service-plan year. One unit is equal to 15 minutes of service.

8.7533.E Mentorship Reimbursement

1. Training to a Member that exceeds the 192-unit limit must be authorized by the Department prior to delivery.

8.7534 Movement Therapy

8.7534.A Movement Therapy Eligibility

1. Movement Therapy is a covered benefit available to Members enrolled in one of the following HCBS waivers:

a. Children's Extensive Support Waiver

b. Children's Habilitation Residential Program

c. Supported Living Services Waiver

8.7534.B Movement Therapy Definition

1. Movement Therapy means the use of music therapy and/or dance therapy as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition, and gross motor skills.

8.7534.C Movement Therapy Inclusions

1. Movement Therapy includes the use of music therapy and/or dance therapy when it addresses an assessed need in the Person-Centered Support Plan.

8.7534.D Movement Therapy Exclusions and Limitations

1. Movement Therapy shall be recommended or prescribed by a therapist or physician who is an enrolled Medicaid Provider. The recommendation must include the medical or behavioral need to be addressed and expected outcome(s) from the therapy. The recommending therapist or physician must monitor the progress and effectiveness of the movement therapy at least quarterly.

2. Movement therapy is only authorized as a treatment strategy for a specific medical or behavioral need and identified in the Member's care plan.

3. Movement Therapy is not available under the waiver if it is available under the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or from a Third-Party Resource.

4. HCBS Children's Extensive Services (CES) Waiver

   a. The following items are excluded and are not eligible for reimbursement:

      i. Fitness training (personal trainer);

      ii. Warm water therapy;

      iii. Experimental treatments or therapies; and

      iv. Yoga.

5. HCBS Supported Living Services (SLS) Waiver:

   a. The following items are excluded and are not eligible for reimbursement:

i. Acupuncture;

ii. Chiropractic care;

iii. Fitness trainer;

iv. Equine therapy;

v. Art therapy;

vi. Warm water therapy;

vii. Experimental treatments or therapies; and

viii. Yoga.

8.7534.E Movement Therapy Provider Agency Requirements

1. Movement therapy shall be provided by a licensed, certified, registered, or accredited professional. Intervention shall be related to an identified medical and/or behavioral need. Movement therapy shall be reimbursed only when:

   a. The provider is licensed, certified, registered or accredited, and be in good standing, by an appropriate national accreditation association.

   b. The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

8.7535 Non-Medical Transportation

8.7535.A Non-Medical Transportation Eligibility

1. Non-medical Transportation (NMT) is a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a. Brain Injury Waiver

   b. Community Mental Health Supports Waiver

   c. Complementary and Integrative Health Waiver

   d. Developmental Disabilities Waiver

   e. Elderly, Blind, and Disabled Waiver

   f. Supported Living Services Waiver

8.7535.B Non-Medical Transportation Definition

1. Non-medical Transportation (NMT) services means transportation which enables eligible Members to gain physical access to non-medical community services and supports, as required by the Person-Centered Support Plan to prevent institutionalization.

2, Non-Medical Transportation Provider (provider) means a Provider Agency that has met all standards and requirements as specified in Section 8.7535.E.

8.7535.C Non-Medical Transportation Inclusions

1. Non-Medical Transportation is authorized for Organized Health Care Delivery System (OHCDS), for the reimbursement only for purchased bus tickets and passes.

2. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Brain Injury (BI) Waiver:

    a. Non-Medical Transportation services shall include, but not be limited to, transportation between the Member's home and non-medical services or supports such as Adult Day Centers, shopping, activities that encourage community integration, counseling sessions not covered by State Plan, and other services as required by the care plan to prevent institutionalization.

3. HCBS Developmental Disabilities (DD) Waiver:

    a. Non-Medical Transportation enables Members to gain access to Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services to include a member’s workplace.

4. HCBS Supported Living Services (SLS) Waiver:

    a. Non-Medical Transportation enables Members to gain access to the community, Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services.

8.7535.D Non-Medical Transportation Exclusions and Limitations

1. HCBS Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Brain Injury (BI) Waiver; HCBS Developmental Disabilities (DD) Waiver; HCBS Supported Living Services (SLS) Waiver:

    a. Non-Medical Transportation services shall not be used to substitute for Non-Emergent Medical Transportation (NEMT, as defined in Section 8.014.1 and as required under 42 C.F.R. 440.170, defined at 42 C.F.R. Section 440.170(a)(4).

b. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the Person-Centered Support Plan.

c. Non-Medical Transportation services shall only be used after the Case Manager has determined that free transportation is not available to the Member.

d. A bus pass or other public conveyance may be used only when it is more cost effective than, or comparable to, the applicable service type and duration. Costs cannot exceed the total Wheelchair Van, Mileage Band 1 allowable per service plan. The most current HCBS Rate Schedule can be found on the Department website.

e. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Brain Injury (BI) Waiver:

   i. A Member is allowed no more than 104 round trip services (208 units), per support plan year, unless otherwise authorized by the Department.

f. HCBS Developmental Disabilities (DD) Waiver:

   i. A Member is allowed no more than 254 round trip services (508 units) to and from Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services, per certification period.

   ii. Transportation acquisition services refers to the purchase or provision of transportation for participants receiving day program services under comprehensive services which enables them to gain access to programs and other community services and resources required by their Individualized Plan/Plan of Care. Funding for transportation activities incidental to the Residential Program are included in the Residential rate.

g. HCBS Supported Living Services (SLS) Waiver:

   i. A Member is allowed no more than 254 round trip services (508) units) to and from Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services, per support plan year.

   ii. Transportation in addition to Day Habilitation Services and Supports, Prevocational Services and Supported Employment Services is limited to no more than 104 round trip services (208

units), per support plan year and will be reimbursed at Mileage Band 1.

8.7535.E HCBS Non-Medical Transportation Provider Agency Requirements

1. Provider Agencies shall maintain all appropriate limits of auto insurance liability as specified in Provider Agency Requirements pursuant to Sections 8.7406(C-D). Provider Agencies shall ensure that each driver rendering NMT meets the following requirements:

    a. Drivers must be 18 years of age or older to render services;

    b. Have at least one year of driving experience;

    c. Possess a valid Colorado driver's license;

    d. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history; and

    e. Complete a Colorado or National-based criminal history record check.

2. Drivers shall be disqualified from serving as drivers for any program Members for any of the following:

    a. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;

    b. A conviction in the State of Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;

    c. A conviction in the State of Colorado, within the seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);

    d. A conviction in the State of Colorado, within the four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15 of Title 18, C.R.S.;

    e. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D) within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6114;

    f. A conviction in the State of Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;

g. A conviction in Colorado within the two (2) years preceding the date the criminal history record check is completed of driving under the influence, as defined in § 42-4-1301(1)(f), C.R.S.; driving with excessive alcohol content, as described in §42-4-1301(1)(g), C.R.S;

h. A conviction within the two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B), 4 C.C.R. 723-6; § 6114 in any other state or in the United States; and

i. For purposes of 4 C.C.R. 723-6; § 6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sentence.

3. Vehicles used during the provision of NMT must be safe and in good working order. To ensure the safety and proper functioning of the vehicles, vehicles must pass a vehicle safety inspection prior to it being used to render services.

   a. Safety inspections shall include the inspection of items as described in Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6104.

   b. Vehicles must be inspected on a schedule commensurate with their age:

      i. Vehicles manufactured within the last five (5) years: no inspection.

      ii. Vehicles manufactured within the last six (6) to ten (10) years: inspected every 24 months.

      iii. Vehicles manufactured eleven (11) years or longer: inspected annually.

      iv. Vehicles for wheelchair transportation: inspected annually, regardless of the manufacture date of vehicle.

   c. The vehicle inspector must be trained to conduct the inspection and be employed by an automotive repair company authorized to do business in Colorado.

4. Transportation providers who maintain a certificate or permit through the Public Utilities Commission (PUC) are not required to meet the above requirements. PUC certificate and permit holders shall submit a copy of the Certification to the Department for verification of provider credentials.

8.7535.F Non-Medical Transportation Provider Agency Reimbursement

1. Reimbursement for Non-Medical Transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services.

2. A Provider Agency's submitted charges shall not exceed those normally charged to the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities.

3. Provider Agency charges shall not accrue when the recipient is not physically present in the vehicle.

4. Providers shall not bill for services before they are an approved Medicaid Provider Agency and may bill only for those NMT services performed by a qualified driver utilizing a qualified vehicle.

8.7536 Palliative/Supportive Care

8.7536.A Palliative/Supportive Care Eligibility

1. Palliative/Supportive Care is a covered benefit available to Members enrolled in the HCBS Children with Complex Health Needs Waiver.

8.7536.B Palliative/Supportive Care Definition

1. Palliative/Supportive Care means a specific program of specialized medical care for Members offered by a licensed healthcare facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care shall be focused on providing Members with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal shall be to improve the quality of life for both the Member and the family. Palliative care may be provided to Members of any age and at any stage in a member’s illness. Palliative care services shall be provided by a Hospice or Home Care Agency staff who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of the CwCHN waiver, Palliative Care shall include Care Coordination and Pain and Symptom Management.

8.7536.C Palliative/Supportive Care Inclusions

1. Palliative/Supportive Care may be provided together with curative treatment and includes:

    a. Care Coordination

        i. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the Member and central coordination of medical and psychological services.

ii. A Care Coordinator will organize an array of services. This approach will enable the Member to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital.

iii. Additionally, a key function of the Care Coordinator shall be to manage the majority of the responsibility, otherwise placed on the Parents, for condensing, organizing, and making accessible to providers critical information that is related to the care and necessary for effective medical management.

iv. Care Coordination does not include Case Management Agency or Case Manager responsibilities.

b. Pain and Symptom Management

i. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the Member's symptoms and pain. Management includes regular, ongoing pain and symptom Assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms.

ii. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

8.7536.D Palliative/Supportive Care Provider Agency Requirements

1. Individuals providing Palliative/Supportive Care services shall be employed by or working under a formal contract with a qualified Medicaid hospice or Home Health Agency.

2. The services shall be provided by Hospice or Home Care Agency staff who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss.

8.7537 Peer Mentorship

8.7537.A Peer Mentorship Eligibility

1. Peer Mentorship is a covered service available to Members enrolled in one of the following HCBS waivers:

a. Brain Injury Waiver

b. Community Mental Health Supports Waiver

c. Complementary and Integrative Health Waiver

d. Developmental Disabilities Waiver

e. Elderly, Blind, and Disabled Waiver

f. Supported Living Services Waiver

8.7537.B Peer Mentorship Definition

1. Peer Mentorship means support provided by peers to promote self-advocacy and encourage community living among Members by instructing and advising on issues and topics related to community living, describing real-world experiences as examples, and modeling successful community living and problem-solving.

8.7537.C Peer Mentorship Inclusions

1. HCBS Elderly, Blind, and Disabled (EBD) Waiver; Community Mental Health Supports (CMHS) Waiver; Complementary and Integrative Health (CIH) Waiver; Brain Injury (BI) Waiver; Supported Living Services (SLS) Waiver, Developmental Disabilities (DD) Waiver:

2. Peer Mentorship means support provided by peers of the Member on matters of community living, including:

   a. Problem-solving issues drawing from shared experience.

   b. Goal Setting, self-advocacy, community acclimation and integration techniques.

   c. Assisting with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups and commissions.

   d. Activities that promote interaction with friends and companions of choice.

   e. Teaching and modeling of social skills, communication, group interaction, and collaboration.

   f. Developing community-Member relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests.

   g. Assisting the person in acquiring, retaining, and improving self-help, socialization, self-advocacy, and adaptive skills necessary for community living.

h. Support for integrated and meaningful engagement and awareness of opportunities for community involvement including volunteering, self-advocacy, education options, and other opportunities identified by the individual.

i. Assisting Members to be aware of and engage in community resources.

8.7537.D Peer Mentorship Service Access and Authorizations

1. To obtain approval for Peer Mentorship, a Member must demonstrate:

   a. A need for soft skills, insight, or guidance from a peer;

   b. That without this service he/she may experience a health, safety, or institutional risk; and

   c. There are no other services or resources available to meet the need.

2. To establish eligibility for Peer Mentorship, the Member must satisfy general criteria for accessing service:

   a. The Member is transitioning from an institutional setting to a Home and Community-Based setting, or is experiencing a qualifying change in life circumstance that affects a Member's stability and endangers their ability to remain in the community,

   b. The Member demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and

   c. The Member demonstrates that they need the service to establish community support or resources where they may not otherwise exist.

8.7537.E Peer Mentorship Exclusions and Limitations

1. Members may utilize Peer Mentorship up to 24 units (six hours) per day, for no more than 160 units (40 hours) per week, for no more than 365 days.

2. Services covered under the State Plan, another waiver service, or by other resources are excluded.

   a. Services or activities that are solely diversional or recreational in nature are excluded.

   b. Peer Mentorship shall not be provided by a peer who receives programming from the same residential location, day program location, or employment location as the Member.

8.7537.F Peer Mentorship Provider Agency Requirements

1. The Provider Agency must ensure services are delivered by a peer mentor staff who:

    a. Has lived experience transferable to support a Member with acclimating to community living through providing them Member advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the Member's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

    b. Is qualified to furnish the services customized to meet the needs of the Member as described in their Person-Centered Support Plan or Provider Care P;

    c. Has completed training from the Provider Agency consistent with core competencies. Core competencies include:

        i. Understanding boundaries;

        ii. Setting and pursuing goals;

        iii. Advocacy for Independence Mindset;

        iv. Understanding of Disabilities, both visible and non-visible, and how they intersect with identity; and

        v. Person-centeredness.

8.7537.G Peer Mentorship Documentation

1. All documentation, including but not limited to, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to Section 8.7405 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request, including:

    a. Start and end time/duration of services;

    b. Nature and extent of services;

    c. Mode of contact (face-to-face, telephone, other);

    d. Description of peer mentorship activities such as accompanying Members to complicated medical appointments or to attend board, advisory and commissions meetings, and support provided interviewing potential providers;

    e. Progress toward support and care plan goals and objectives; and

f. Provider's signature and date.

8.7537.H Peer Mentorship Provider Agency Reimbursement

1. Peer Mentorship services are reimbursed based on the number of units billed, with one (1) unit equal to 15 minutes of service.

2. Payment for Peer Mentorship shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the care plan.

8.7538 Personal Care

8.7538.A Personal Care Eligibility

1. Personal Care is a covered benefit available to Members enrolled in CFC.

8.7538.B Personal Care Definition

1. Personal Care means services provided to an eligible Member to meet the Member's physical, maintenance, and supportive needs through hands-on assistance, supervision and/or cueing. These services do not require a nurse's supervision or physician's orders.

8.7538.C Personal Care Inclusions

1. Tasks included in Personal Care:

    a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;

    b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask to or from the Member's face;

    c. Preventative skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays and/or solutions, and monitoring for skin changes.

    d. Bladder/Bowel Care:

        i. Assisting Member to and from the bathroom;

        ii. Assistance with bed pans, urinals, and commodes;

        iii. Changing incontinence clothing or pads;

iv. Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v. Emptying ostomy bags; and

vi. Perineal care.

e. Personal hygiene:

i. Bathing including washing, shampooing;

ii. Grooming;

iii. Shaving with an electric or safety razor;

iv. Combing and styling hair;

v. Filing and soaking nails; and

vi. Basic oral hygiene and denture care.

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints, and the application of artificial limbs when the Member is able to assist or direct.

g. Transferring a Member when the Member has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the Member and Direct Care Worker are fully trained in the use of the equipment and the Member can direct and assist with the transfer.

h. Mobility assistance when the Member has the ability to reliably balance and bear weight or when the Member is independent with an assistive device.

i. Positioning when the Member is able to verbally or nonverbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.

j. Medication Reminders when medications have been preselected by the Member, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:

i. Medication reminders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;

ii. Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications,

handing the appropriately marked medication minder container to the Member and opening the appropriately marked medication minder if the Member is unable to do so independently.

k. Accompanying includes the following:

i. Going with the Member to medical appointments, as indicated on the support plan, to provide one or more personal care tasks, or assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the Direct Care Worker; and/or

ii. Going with the Member to run errands such as grocery shopping or banking and providing one or more personal care tasks as needed during the trip.

l. Homemaker Services, as described at Section 8.7527, may be provided by personal care staff, if provided during the same visit as personal care.

m. Cleaning and basic maintenance of durable medical equipment.

n. Protective Oversight means providing active line of sight supervision during which immediate intervention is required to prevent harm when a member's disability, memory, or cognitive functioning-related behaviors or impairment place the member, others, or property at risk. Protective Oversight includes intervention time including, but limited to, verbal redirection, blocking access to hazards, removing dangerous items, or hands-on guidance. Protective Oversight shall only be approved when there is documented evidence of recurring disability-related risks requiring regular and predictable intervention within the last 12 months. The members' service plan must include the frequency, scope and duration of intervention required..

a. For children under age 18, Protective Oversight may be authorized only when the level of supervision requiring intervention is substantially greater than what is typical for a child of the same age without disabilities. Protective Oversight cannot be authorized for routine childcare, typical parental monitoring or supervision that is age-appropriate and expected for children of the same age.

b. Protective Oversight Exclusions:

i. Protective Oversight shall not be authorized for purposes of companionship, childcare, general supervision, reassurance, emergency or crisis intervention, maintaining line of sight supervision without an intervention, or routine monitoring that is not necessary to address a disability-related safety risk.

ii. Protective Oversight shall not include any restrictive practices unless a documented Rights Modification per 8.7001.A.17. is in place prior to the provision of services.

iii. Protective Oversight alone cannot be the sole reason for the visit/services.

o. Personal Care Services includes the option for the Acquisition, Maintenance, and Enhancement of Skills (AME) task when the support is related to functional skills training and is desired by the member to accomplish Personal Care tasks to increase their independence and reduce supports needed in the home and community.

i. Detailed, task-related goals shall be documented by case manager in the Person-Centered Support Plan, including documentation monitoring progress and any decrease in human assistance previously authorized.

ii. AME services shall include direct training and instruction to the Member in performing Personal Care tasks.

iii. The provider or attendant shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task.

2. All tasks must meet Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older. If additional hours are needed beyond the Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults, Case Managers shall follow the CFC Direct Care Services Exception Request process described in Section 8.7607.A.

3. Authorization of Personal Care tasks for Members under 18 must be limited to services that exceed those considered part of Parental or Legal Guardian of a Minor Responsibility as defined in Section 8.7502.KK.

8.7538.D Personal Care Exclusions and Limitations

1. Personal Care services shall not include any skilled care. Skilled care is available through Health Maintenance Activities services and is defined in Section 8.7523. Health Maintenance Activities shall not be provided as Personal Care services under CFC regardless of the level of the training, certification, or supervision of the Personal Care employee.

2. All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the Member's needs.

3. Personal Care Provider Agencies may decline to perform any specific task, if the supervisor or the personal care staff feels uncomfortable about the safety of the Member or the personal care staff, regardless of whether the task may be included in the definition above.

4. Family Members must provide Personal Care in accordance with the following:

    a. Family Members may be employed by Personal Care Agencies that are licensed and certified, as applicable to programs offered by the agency, to provide Personal Care Services to relatives enrolled a waiver subject to the conditions below.

    b. The Family Member shall meet all requirements for employment by a Personal Care Agency that is licensed and certified, as applicable to programs offered by the agency, and shall be employed and supervised by the Personal Care Agency.

    c. The Family Member providing personal care shall be reimbursed, an hourly rate, by the Personal Care Agency which employs the Family Member, with the following restrictions:

        i. The reimbursement for Personal Care units shall cover the Personal Care Agency's costs for unemployment insurance, worker's compensation, FICA, training and supervision, and all other administrative costs.

        ii. When CFC funds are utilized for reimbursement of Personal Care services provided by the Member's family, the home care allowance may not be used to reimburse the family.

5. Billing for travel time to and from the Member's home at the beginning and end of the visit is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.

6. This service is subject to the following Annual CFC Service Soft Caps: Members shall not be authorized for more than 2,500 hours of Personal Care per PCSP year. Case Managers may request additional hours through the Department prescribed exception process as defined at Section 8.7607.A.

7. Caregivers must adhere to the Weekly Caregiver Limit and Per Day Hourly Limit as defined at Section 8.7419.

8.7538.E Personal Care Provider Agency Requirements

1. In addition to the training requirements described in Section 8.7409 HCBS Provider Agency Requirements, Personal Care Provider Agencies must be licensed and certified, as applicable to programs offered by the agency, through

Colorado Department of Public Health and Environment. Personal Care Provider Agencies shall assure and document that all Personal Care staff have received at least twenty hours of training, or have passed a skills validation test, in the provision of unskilled Personal Care as described in Sections 8.7538.C and 8.7538.D. Training, or skills validation, shall include the areas of bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care, medication reminding, homemaking, and Protective Oversight. Training shall also include instruction in basic first aid, and training in infection control techniques, including Universal Precautions. Training or skills validation shall be completed prior to service delivery, except for components of training that may be provided in the Member's home, in the presence of the supervisor.

a. All employees providing personal care shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of personal care staff, as specified above. Supervision shall include, but not be limited to, the following activities:

    i. Orientation of staff to Agency policies and procedures.

    ii. Arrangement and documentation of training.

    iii. Informing staff of policies concerning advance directives and emergency procedures.

    iv. Oversight of scheduling, and notification to Members of changes; or close communication with scheduling staff.

    v. Written assignment of duties on a Member-specific basis.

    vi. Meetings and conferences with staff as necessary.

    vii. Supervisory visits to Member's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, Member specific or procedure-specific training of staff, observation of Member's condition and care, and Assessment of Member's satisfaction with services. At least one of the assigned personal care staff must be present at supervisory visits at least once every three months.

        1) Supervision should be flexible to the needs of the member and may be conducted via phone, video conference, telecommunication, or in person.

            a) If there is a safety concern with the services, the Provider Agency must make every effort to conduct an in-person Assessment.

b) The Provider Agency must conduct Direct Care Worker (DCW) supervision to ensure that Member care and treatment are delivered in accordance with a plan of care that addresses the Member's needs.

viii. Investigation of Complaints and Incidents.

ix. Counseling with staff on difficult cases, and potentially dangerous situations.

x. Communication with the Case Managers, the physician, and other providers on the care plan, as necessary to assure appropriate and effective care.

xi. Oversight of record keeping by staff.

b. A Personal Care Agency may be denied or terminated from participation in Colorado Medicaid, according to Section 8.7403. Additionally, personal care agencies may be terminated for the following:

i. Improper Billing Practices:

1) Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the Member's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.7400.

2) Billing for excessive hours that are not justified by the documentation of services provided, or by the Member's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as much time as that authorized.

3) Billing for time spent by the personal care provider performing any tasks that are not allowed according to regulations in Section 8.7538. This includes but is not limited to companionship, financial management, transporting of Members, skilled personal care, or delegated nursing tasks.

4) Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker Agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that

defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

a) One employee makes one visit, and the Agency bills Medicaid for one home health aide visit and bills all the hours as personal care or homemaker.

b) One employee makes one visit, and the Agency bills for one home health aide visit, and bills some of the hours as personal care or homemaker, when the total time spent on the visit does not equal at least 2 1/2 hours plus the number of hours billed for personal care and homemaker.

c) Two employees make contiguous visits, and the Agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 1/2 hours.

d) One or more employees make two or more visits at different times on the same day, and the Agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related, to the Member's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

e) One or more employees make two or more visits on different days of the week, and the Agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the Member's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f) Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

5) For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour

increments, all the practices described in 4 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

6) Billing for travel time Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.

ii. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services Without Also Receiving Payment for Home Health Services.

1) A personal care/homemaker agency that is also certified as a Medicaid Home Health Agency may be terminated from Medicaid participation if the agency refuses to provide necessary and allowed HCBS personal care or homemaker services to Members who do not need Home Health services or who receive their Home Health services from a Home Health Agency not affiliated with the personal care/homemaker agency.

iii. Prior Termination from Medicaid Participation.

1) A personal care/homemaker agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have been previously involuntarily terminated from Medicaid participation, regardless of the provider type of the entity that was terminated.

iv. Abrupt Prior Closure

1) A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed without proper prior Member notification regardless of the provider type of the entity that closed abruptly.

2. A personal care/homemaker agency may be denied or terminated from Medicaid participation if:

a. The agency scheduled or reimbursed a single caregiver for more than 16 hours of care in a calendar day for one or more members collectively across Personal Care, Homemaker, Health Maintenance Activities, Private Duty Nursing, and/or Long-Term Home Health except in an Emergency Situation as defined at Section 8.7419.

b. The agency scheduled or reimbursed a single caregiver for more than 56 hours of direct care per week per member across Personal Care, Homemaker, Health Maintenance Activities, LTHH-Home Health Aide, and/or LTHH-Nursing Services except in an Emergency Situation as defined at Section 8.7419.

8.7538.F Personal Care Reimbursement Requirements

1. Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of 15 minutes. The maximum unit rate shall be adjusted by the State as funding becomes available.

2. Payment does not include travel time to or from the Member's residence.

3. When personal care services are used to provide respite for unpaid primary caregivers, the exact services rendered must be specified in the documentation.

4. If a visit by a personal care staff includes some homemaker and personal care services, the visit shall be billed separately in accordance with services provided.

5. If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.

6. There shall be no reimbursement under this section for personal care services provided in certified, uncertified, licensed, or unlicensed Congregate Facilities.

8.7539 Prevocational Services

8.7539.A Prevocational Service Eligibility

1. Prevocational services are available as a covered benefit to Members enrolled in one of the following HCBS waivers:

   a. Developmental Disabilities Waiver

   b. Supported Living Services Waiver

8.7539.B Prevocational Service Definition

1. Prevocational services are provided to prepare a Member for paid community employment by increasing general employment skills. Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the Member’s private residence or other residential living arrangement.

8.7539.C Prevocational Service Inclusions

1. Prevocational Services consist of teaching concepts associated with performing compensated work including attendance, task completion, problem solving, and safety skills.

8.7539.D Prevocational Service Access and Authorizations

1. Prevocational Services are provided to support the Member to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual Person-Centered Support Plan demonstrates this need based on an annual assessment.

2. A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment.

3. Documentation shall be maintained in the file of each Member that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. Section 1400 et seq.).

8.7539.E Prevocational Service Requirements

1. Members shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations and § 8-6-108.7 C.R.S.

8.7539.F Prevocational Service Exclusions and Limitations

1. Prevocational Services are not primarily directed at teaching job specific skills.

2. One unit is equal to fifteen minutes of service. The following unit limitations apply:

    a. Supported Living Services Waiver:

        i. Prevocational services, in combination with other Day Habilitation services as defined at Section 8.7517 and Supported Employment services, are limited to 7,112 units per support plan year.

    b. Developmental Disabilities Waiver:

        i. Prevocational services, in combination with Day Habilitation services as defined in Section 8.7517, are limited to four thousand eight hundred (4,800) units.

        ii. When used in combination with Supported Employment services as defined in Section 8.7549, the total number of units available for

Prevocational services in combination with Day Habilitation services will remain at 4,800 units, and the cumulative total, including Supported Employment services, may not exceed 7,112 units.

8.7539.F Prevocational Service Provider Agency Requirements

1. Providers of Prevocational Services Program Management shall have either:

   a. Baccalaureate or higher degree from an accredited college or university in the area of Vocational Rehabilitation, Education, Social Work, Psychology, or related field and one year of successful experience in human services, or

   b. An associate's degree from an accredited college and two years of successful experience in human services, or

   c, Four years successful experience in human services.

8.7540 Primary Caregiver Education

8.7540.A Primary Caregiver Education Eligibility

1. Primary Caregiver Education is a covered benefit available to Members enrolled in the HCBS Children's Extensive Support Waiver.

8.7540.B Primary Caregiver Education Definition

1. Primary Caregiver Education provides education in techniques that enhance the ability of Parents and other primary caregivers to support a Member's needs and strengths.

8.7540.C Primary Caregiver Education Inclusions

1. Primary Caregiver Education is authorized for Organized Health Care Delivery System (OHCDS).

2, Primary Caregiver Education includes:

   a. Consultation and direct service costs for training Parents or other primary caregivers in techniques to assist in caring for the Member's needs, including sign language training,

   b. Special resource materials,

   c. Cost of registration for Parents or other primary caregivers to attend conferences or educational workshops that are specific to the Member's disability, and

d. Cost of membership to caregiver support or information organizations and publications designed for Parents and primary caregivers of children with disabilities.

8.7540.D Primary Caregiver Education Exclusion/Limitations

1. The maximum service limit for Primary Caregiver Education is $1,000 per support plan year.

2. The following items are specifically excluded and not eligible for reimbursement:

   a. Transportation;

   b. Lodging;

   c. Food; and

   d. Membership to any political organizations or any organization involved in lobby activities.

8.7541 Residential Habilitation Service and Supports

8.7541.A Residential Habilitation Service and Supports Eligibility

1. Residential Habilitation Service and Supports is a covered benefit available to Members enrolled in the HCBS Developmental Disabilities Waiver.

8.7541.B Residential Habilitation Service and Supports Definition

1. Residential Habilitation Service and Supports (RHSS) provide service, supports, and supervision up to 24 hours per day.

8.7541.C Residential Habilitation Service and Supports Inclusions

1. Services are provided to ensure the health, safety and welfare of the Member, and to provide training and habilitation services or a combination of training (i.e., instruction, skill acquisition) and supports in the areas of personal, physical, mental and social development and to promote independence, self-sufficiency and community inclusion. Services and supports are designed to meet the unique needs of each Member determined by the assessed needs, personal goals, and other input provided by the Member Identified Team and to provide access to and participation in typical activities and functions of community life.

2. Members receiving Residential Habilitation Service and Supports must have up to 24-hour supervision. Supervision may be on-site (direct service provider or caregiver is present) or accessible (direct service provider or caregiver is not on site but available to respond when needed). Staffing arrangements must be adequate to meet the health, safety and welfare of the Member and the needs of

the Member as determined by the Person-Centered Support Plan. The Provider Agency is responsible for verifying that any direct care provider they employ or contract with has the capacity to serve the Members in their care, as described in the care plan.

3. Members are presumed able to manage their own funds and possessions unless otherwise documented in the Person-Centered Support Plan and Provider Care Plan.

4. Residential Habilitation Service and Supports includes medical and health care services that are integral to meeting the daily needs of the Member.

    a. Individual Residential Support Services (IRSS)

        i. IRSS includes skilled care that may be performed by a Certified Nursing Assistant (CNA) or lower.

    b. Group Residential Services and Supports (GRSS)

        ii. GRSS includes nursing services set forth at 6 C.C.R. 1011-1 Chapter 8, Part 16.

8.7541.D Residential Habilitation Service and Supports Provider Agency Requirements

1. The Provider Agency must send documented notification to the Member, Guardians, other Legally Authorized Representatives, and the Case Manager at least 30 days prior to proposed changes in setting placements.

    a. If an immediate move is required for the protection of the Member, the Provider Agency must send documented notification to the Member, Guardians, other Legally Authorized Representatives, and the Case Manager as soon as possible before the move or no later than three days after the move.

    b. The Provider Agency must include the Member, Guardians, and other Legally Authorized Representatives, as appropriate, in planning subsequent placements. Any Member of the Member Identified Team may request a meeting to discuss the change in placement.

    c. When a Member moves settings or providers, all residential providers involved must be present for the move, or designate a Legally Authorized Representative to be present, and must ensure all possessions, medications, money and pertinent records are transferred to the Member within 24 hours.

d. A Member, Guardians, or other Legally Authorized Representative, as appropriate, wishes to contest a change in setting shall follow the Grievance procedure of the Agency.

2. The Provider Agency is responsible for monitoring conditions at the setting to ensure compliance and must provide oversight and guidance to safeguard the health, safety, and welfare of the Member.

3. The Provider Agency must provide for and document the regular on-site monitoring of Residential Habilitation Service and Supports. Provider's must conduct an on-site visit of each IRSS or GRSS setting before a Member moves in, and at a minimum once every quarter, with at least one visit annually that is unscheduled. On-site monitoring of IRSS and GRSS settings must include, but not be limited to:

a. Inspection of all smoke alarms and carbon monoxide detectors;

b. Ensuring all exits are free from blockages to egress;

c. Review of each Member's emergency and disaster Assessment; and

d. Medication administration records and physician orders.

8.7542 Individual Residential Service and Supports (IRSS)

8.7542.A Individual Residential Service and Supports (IRSS) Eligibility

1. Individual Residential Service and Supports (IRSS) is a covered benefit available to Members enrolled in the HCBS Developmental Disabilities Waiver.

8.7542.B Individual Residential Service and Supports (IRSS) Definitions

1. Individual Residential Service and Supports (IRSS) use a variety of living arrangements to meet the unique needs for support, guidance and habilitation of each Member.

a. IRSS settings include, but are not limited to:

i. A setting owned, leased or controlled by the Provider Agency;

ii. A setting of a Family member;

iii. The Member's own setting; or

iv. A Host Home.

1) The Host Home is the primary setting of the provider, which means that the Host Home provider occupies the setting 75 percent of the time. The Host Home provider may not

contract to provide services to more than three Members, inside or outside of the Host Home, at any given time.

8.7542.C Individual Residential Service and Supports (IRSS) Provider Agency Requirements

1. Oversight

   a. The Provider Agency is responsible for controlling the daily operations and management of the Provider Agency and all residential settings in which the Provider Agency employees or contractors provide services. The provider must provide sufficient oversight and guidance and have established written procedures to ensure that the health and medical needs of the Member are addressed. This includes:

      i. Each Member must have a primary physician;

      ii. Each Member must receive a medical evaluation at least annually unless a greater or lesser frequency is specified by their primary physician. If the physician specifies an annual evaluation is not needed, a medical evaluation must be conducted no less frequently than every two years;

      iii. Each Member must be encouraged and assisted in getting a dental evaluation annually;

      iv. Other medical and dental assessments and services must be completed as the need for these is identified by the physician, dentist, other medical support personnel or the Member Identified Team; and

      v. Records must contain documentation of:

         1) medical services provided;

         2) results of medical evaluations/assessments and of follow-up services required, if any;

         3) acute illness and chronic medical problems; and,

         4) weight taken annually or more frequently, as needed.

   b. The Provider Agency shall make available to Members nutritionally balanced meals. Based on an Assessment of the Members capabilities, preferences and nutritional needs, the provider may provide guidance and support to monitor nutritional adequacy.

i. Therapeutic diets must be prescribed by a licensed physician or dietician.

ii. Even if recommended by the Member's physician or other practitioner, staff interventions that interfere with the Member's choice of food, freedom to determine their own activities, or exercise of any other rights are Rights Modifications that must comply with Section 8.7001.B.

c. IRSS may be provided to no more than three Members in a single setting. For each Member in a setting, the Provider Agency must ensure the following criteria are met and documented:

i. The Members involved elect to live in the setting;

ii. Each Member must have their own bedroom, unless they elect to share a bedroom with a roommate of their choice, which must be documented in the service plan;

iii. Back-up providers are identified, available and agreed upon by the Member and provider. When a back-up provider is not available, the Provider Agency assumes responsibility for identifying a provider;

iv. The Provider Agency and Case Management Agency of each Member in the setting must be involved in the coordination of placement of each Member;

v. Members are afforded regular opportunities for community inclusion of their choice;

vi. Members are afforded individual choice, including preference to live near family;

vii. Distance from other settings (e.g., apartments, houses) of Members is examined so that persons with Developmental Disabilities are not grouped in a conspicuous manner;

d. For the placement of a Member into a three-person setting, the following factors must be examined and documented to determine reasonableness of the placement:

i. Level of Care and needs of each Member in the setting;

ii. Availability to support and provide supervision to Members; and,

iii. Each Member's ability to evacuate.

e. When three Members reside in a single setting, the Provider Agency must conduct monthly monitoring of the setting.

f. Upon enrollment in services, the Provider Agency must assess each Member's ability to care for their safety needs and take appropriate action in case of an emergency. The Assessment must be kept up to date and, at a minimum, address the following emergencies and disasters:

i. Fire;

ii. Severe weather and other natural disasters;

iii. Serious accidents and illness;

iv. Assaults; and,

v. Intruders.

g. There must be a written plan for each Member addressing how the emergencies specified above will be handled. The plans must be based on an assessment, maintained current and shall, at minimum, address:

i. Specific responsibilities/actions to be taken by the Member, approved caregivers or other providers of supports and services in case of an emergency;

1) How the Member will evacuate in case of fire by specifying, at minimum, two exit routes from floors used for sleeping and the level of assistance needed; and

2) Telephone access (by the Member or with assistance) to the nearest poison control center, police, fire and medical services.

h. Safety plans and evacuation procedures must be reviewed and practiced at sufficient frequency and varying times of the day, but no less than once a quarter, to ensure all persons with responsibilities for carrying out the plan are knowledgeable about the plan and capable of performing it. All safety plans must be on site at the setting and be reviewed by the Provider Agency during each on-site monitoring visit.

i. Each Provider Agency must provide quarterly housing and Member updates to the Department or its agent through a specified data collection platform. Failure to provide these quarterly updates may result in payment suspension.

2. Contracts

a. The Provider Agency must have a written contract with each direct service provider that is not directly employed by the Provider Agency and is providing IRSS under the Provider Agency's authority, regardless of the setting type. This includes but is not limited to Host Home providers and Family caregivers not directly employed by the Provider Agency.

i. A current list of the above-mentioned contracted IRSS providers and their accompanying contracts must be on file with the program approved Provider Agency and a copy must be provided to the Department or its agent upon request.

ii. Each contract must be in writing and contain the following information:

1) Name of contracted IRSS provider;

2) Responsibilities of each party to the contract, including, but not limited to, responsibility for the safety and accessibility of the physical environment of the setting;

3) An agreement outlining the living arrangements, monitoring of the home, IRSS provider's duties, and any limitations on the IRSS providers duties;

4) Expectations that Members be provided opportunities for informed choice over a variety of daily choices similar to those exercised by non-Members;

5) Process for correcting non-compliance;

6) Process for termination of the contract;

7) Process for modification or revision of the contract;

8) Process for relocation of the Member if they are in immediate jeopardy of actual or potential for serious injury or harm;

9) Process for coordinating the care of the Member;

10) Payment rate and method;

11) Beginning and ending dates; and

12) A clause that states the contracted IRSS provider shall not sub-contract with any entity to perform in whole the work or services required under the IRSS benefit.

iii. If a contract is terminated with a contracted IRSS provider due to health, safety or welfare concerns, the provider must report to the following parties:

1) Within four days to the Department or its agent regarding the cited reason for termination of a contracted IRSS provider.

2) Within four days to the Guardian or other Legally Authorized Representative and Case Manager of the Member.

iv. The Provider Agency must require each contracted direct service provider providing IRSS to document each approved caregiver(s) and report to the Provider Agency the names of all persons that reside in the setting. Members and/or Guardians have a right to request and receive from the rendering provider a list of all direct service and backup providers that are approved to provide them services. No backup provider may be hired without provider approval. The Provider Agency must ensure criminal background checks are completed for any non-Member over the age of eighteen (18) who lives in the setting.

v. The IRSS direct service provider is prohibited from conduct that would pose a risk to the health, safety and welfare of the Member including the Members mental health.

3. Living Environment

a. The Provider Agency has the responsibility for the living environment, regardless of the setting type.

b. Settings of Members must, at minimum, meet standards set forth in the Colorado Division of Housing (DOH) IRSS Inspection Protocol. The following setting types must pass the Division of Housing IRSS Inspection Protocol every two years:

i. All Host Homes; and

ii. All IRSS settings that are owned or leased by a provider.

1) All IRSS settings must be announced to and recorded by Division of Housing within 90 days of activation by a provider and the placement of a Member

2) An inspection by Division of Housing is not required prior to the placement of a Member if the setting has been inspected by the provider and passes all residential safety requirements.

c. The Provider Agency must have a protocol in place for the emergency placement of the Member if a setting is deemed not safe by the Division of Housing (DOH)

d. The setting (exterior and interior) and grounds must:

i. Be maintained in good repair;

ii. Protect the health, comfort and safety of the Member; and

iii. Be free of offensive odors, accumulation of dirt, rubbish and dust.

e. There must be two means of exit from floors with rooms used for sleeping. Exits must remain clear and unobstructed.

f. The Provider Agency must ensure entry to the setting and an emergency exit is accessible to Members, including Members utilizing a wheelchair or other mobility device.

g. Bedrooms must meet minimum space requirements (single 100 square feet, double 80 square feet per person). (Not applicable for studio apartments.)

h. Adequate and comfortable furnishings and supplies must be provided and maintained in good condition.

i. A fire extinguisher must be available in each setting. Presence of an operational fire extinguisher shall be confirmed by the provider during each on-site monitoring visit.

i. Provider Agencies must follow manufacturer specifications and expiration dates for all fire extinguishers.

j. Smoke alarms and carbon monoxide detectors must be installed in the proper locations in each home to meet Housing and Urban Development (HUD) requirements and/or local ordinances. Smoke and carbon monoxide detectors shall be tested during each on-site monitoring visit by the provider.

8.7543 Group Residential Services and Supports (GRSS)

8.7543.A Group Residential Services and Supports Eligibility

1. Group Residential Services and Supports (GRSS) is a covered benefit available to Members enrolled in the HCBS Developmental Disabilities Waiver.

8.7543.B Group Residential Services and Supports Definitions

1. Group Residential Services and Supports (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) Members receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment (CDPHE) as a residential care facility or residential community setting for Members with Developmental Disabilities.

    a. GRSS is a licensed setting and must comply with all regulations set forth at 6 C.C.R. 1011-1 Chapter 8.

8.7543.C Group Residential Services and Supports Provider Reimbursement Requirements

1. Reimbursement for GRSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of Members or to meet the requirements of the applicable life safety code.

2. Reimbursement does not include room and board.

8.7544 Remote Supports

8.7544.A Remote Supports Eligibility

1. Remote Supports is a covered benefit available to Members enrolled in CFC.

8.7544.B Remote Support Definitions

1. Backup Support Person means the person who is responsible for responding in the event of an emergency or when a Member receiving Remote Supports otherwise needs assistance or the equipment used for delivery of Remote Supports stops working for any reason.

2. Monitoring Base means the off-site location from which the Remote Supports Provider monitors the Member.

3. Remote Supports means the provision of support by staff at a HIPAA compliant Monitoring Base who engage with a Member through live two-way communication to provide prompts and respond to the Member's health, safety, and other needs identified through a Person-Centered Support Plan to increase their independence in their home and community when not engaged in other HCBS services.

4. Remote Supports Service Plan means a document that describes the Member's need for remote support, devices that will be used, number of service hours, emergency contacts, and a safety plan developed between the Member and Remote Supports Provider Agency in consultation with their Case Manager.

5. Remote Supports Provider means the Provider Agency selected by the Member to provide Remote Supports. This provider supplies the monitoring base, the remote support staff who monitor a Member from the monitoring base, and the remote support technology equipment necessary for the receiving Remote Supports,

6. Sensor means equipment used to notify the Remote Supports Provider of a situation that requires attention or activity which may indicate deviations from routine activity and/or future needs. Examples include but are not limited to, seizure mats, door sensors, floor sensors, motion detectors, heat detectors, and smoke detectors.

8.7544.C Remote Supports Inclusions

1. Remote Supports that help a Member with Activities of Daily Living and Instrumental Activities of Daily Living tasks that can be completed through virtual two-way live communication with prompts, supervision, or coaching from a Remote Supports Provider are a covered benefit.

2. Remote Supports includes prompting, coaching, and virtual supervision with Activities of Daily Living and Instrumental Activities of Daily Living either in a Member's home or community that are documented in the Member's Remote Supports Service Plan.

3. Remote Supports Technology services shall include but are not limited to the following technology options:

    a. Motion sensing system;

    b. Radio frequency identification;

    c. Live audio feed;

    d. Web-based system; or,

    e. Another device that facilitates two-way communication.

4. Remote Supports includes the following general provisions:

    a. Remote Supports shall only be approved when it is the Member's preference and will reduce the assessed need for in-person care.

    b. The Member, their Case Manager, and the selected Remote Supports Provider shall determine whether Remote Supports is sufficient to ensure the Member's health and welfare.

    c. Remote Supports shall be provided in real time by awake staff at a Monitoring Base using the appropriate technology. While Remote

Supports is being provided, the Remote Supports staff shall not have duties other than the provision of Remote Supports.

8.7544.D Remote Supports Exclusions and Non-Benefit Items

1. Remote Supports shall be authorized for Members who have the physical and mental capacity to utilize the particular system(s) that meet needs identified during the person-centered planning process, and which the Member prefers to be met with virtual support. .

2. Remote Supports shall not be authorized under CFC if the service or device is available as a state plan Medicaid benefit.

3. Remote Supports shall not be performed concurrently or be duplicative of any other HCBS benefit or service.

4, Remote Supports shall not provide any service that is authorized for Telehealth at Section 8.7562.

5. Remote Supports Technology shall only be used for the delivery of Remote Supports.

6. Remote Supports is available to Members to foster developmentally appropriate independence and not to replace informal support.

7. Video or audio monitoring and recording is not allowed. Interactions between the Remote Support Provider and the Member should be through live, two-way communication that is on-demand, scheduled, or alerted by a sensor as agreed to by the Member in the Remote Supports Service Plan.

8. Devices used for communication shall not be mounted in a bedroom or bathroom and must be able to be moved by the Member to a location of their choice.

9. The following are not benefits of Remote Supports:

    a. The cost of meals, household supplies, cell phones, internet access, landline telephone lines, and cellular phone voice or data plans.

    b. Augmentative communication devices and communication boards;

    c. Hearing aids and accessories;

    d. Phonic ears;

    e. Environmental control units;

    f. Computers and computer software unrelated to the provision of Remote Supports;

g. Wheelchair lifts for automobiles or vans;

h. Exercise equipment, such as exercise cycles;

i. Hot tubs, Jacuzzis, or similar items.

8.7544.E Remote Supports Provider Agency Requirements

1. The Remote Supports Provider must comply with the Provider Agency Regulations at Section 8.7400 et seq. and the provider enrollment agreement.

2. The Remote Supports Provider shall meet with the Member to identify Remote Supports service needs and develop services in a Remote Supports Service Plan that will be sent to the Member's Case Manager. The Remote Supports Care Plan must include:

   a. The location(s) where the Member will receive the service,

   b. A description of tasks/services the Remote Supports Provider will perform for the Member,

   c. The technology devices determined necessary to help the Member meet their identified need

   d. Family or providers with whom the Member has authorized the Remote Supports Provider to share information with and a safety plan that includes emergency contact information and medical conditions, if any, that should be shared with emergency response personnel if the provider must contact them, and

   e. An up-to-date list of Backup Support Person(s). Backup support may be provided on an unpaid basis by a Family Member, friend, or other person selected by the Member or on a paid basis by an Agency provider.

3. Remote Supports Providers shall conform to the following standards for electronic monitoring services:

   a. Properly trained individuals shall install all equipment, materials, or appliances, and the installer and/or provider of electronic monitoring shall train the Member in the use of the device.

   b. All equipment, materials, or appliances shall be tested for proper functioning at the time of installation, and at periodic intervals after that, and be maintained based on the manufacturer's recommendations. Any malfunction shall be promptly repaired, and equipment replaced when necessary, including buttons and batteries.

c. All telephone calls generated by monitoring equipment shall be toll-free, and all Members shall be allowed to run unrestricted tests on their equipment.

d. Remote Supports Providers shall send written information to each Member's Case Manager about the system, how it works, and how it will be maintained in the Remote Support Plan.

e. The Remote Support Provider shall provide a Member who receives Remote Supports with initial and ongoing training on how to use the Remote Supports system(s) including regular confirmation that the Member knows how to turn systems on and off.

4. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.

5. The Remote Supports Provider shall have a backup power system (such as battery power and/or generator) in place at the Monitoring Base in the event of electrical outages. The Remote Supports Provider shall have additional backup systems and additional safeguards in place which shall include, but are not limited to, contacting the Backup Support Person in the event the Monitoring Base System stops working for any reason.

6. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.

7. If a known or reported emergency involving a Member arises, the Remote Supports Provider shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the Backup Support Person. The Remote Supports Provider shall maintain contact with the Member during an emergency until emergency personnel or the Backup Support Person arrives.

8. The Backup Support Person shall verbally acknowledge receipt of a request for assistance from the Remote Supports Provider. Text messages, email, or voicemail messages will not be accepted as verbal acknowledgment.

9. When a Member requests in-person assistance, the Backup Support Person shall arrive at the Member's location within a reasonable amount of time based on team agreement to be specified in documentation maintained by the Remote Support Provider.

10. When a Member needs assistance, but the situation is not an emergency, the Remote Supports Provider shall:

    a. Address the situation from the Monitoring Base, or,

    b. Contact the Member’s Backup Support Person if necessary.

11. The Remote Support Provider shall maintain detailed and current written protocols for responding to a Member's needs, including contact information for the Backup Support Person to provide assistance.

12. The Remote Support Provider shall maintain documentation of the protocol to be followed should the Member request that the equipment used for delivery of Remote Supports be turned off.

13. The Remote Supports Provider shall maintain daily service provision documentation that shall include the following:

    a. Type of Service,

    b. Date of Service,

    c. Place of Service,

    d. Name of Member receiving service,

    e. Medicaid identification number of Member receiving service,

    f. Name of Remote Supports Provider,

    g. Identify the Backup Support Person and their contact information, if/when utilized.

    h. Begin and end time of the Remote Supports service,

    i. Begin and end time of the Remote Supports service when a Backup Support Person is needed on site,

    j. Begin and end time of the Backup Support Person when on site, whether paid or unpaid,

    k. Number of units of Remote Supports service delivered per calendar day,

    l. Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the Member’s current Person-Center Support Plan, which shall be communicated to the Member’s Case Manager.

8.7544.F Remote Supports Reimbursement

1. For Remote Supports, the reimbursement unit shall include one unit per installation/equipment purchase and/or the units as designated on the Department’s fee schedule and/or billing manuals for ongoing Remote Supports service.

2. Remote Supports in Provider -Owned, -Controlled, or Congregate Facility settings are not eligible for reimbursement by the Colorado Medicaid program.

8.7545 Adult Respite

8.7545.A Adult Respite Eligibility

1. Adult Respite is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Brain Injury Waiver

    b. Community Mental Health Supports Waiver

    c. Complementary and Integrative Health Waiver

    d. Elderly, Blind, and Disabled Waiver

    e. Supported Living Services Waiver

8.7545.B Adult Respite Definition

1. Adult Respite care means services provided to an eligible Member on a short-term basis because of the absence or need for relief of those persons who normally provide the care.

8.7545.C Adult Respite Inclusions

1. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver;

    a. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite Member, as ordered by the physician.

    b. An Alternative Care Facility shall provide all the Alternative Care Facility services as listed at Section 8.7506, which are required by the individual respite Member.

    c. Respite may be provided in the Member's home, the home of the respite provider, or in the community.

2. HCBS Brain Injury (BI) Waiver

    a. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite Member, as ordered by the physician.

b. Respite may be provided in the Member's home, home of the respite provider, or in the community.

3. HCBS Community Mental Health Supports (CMHS) Waiver

a. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite Member, as ordered by the physician.

b. An Alternative Care Facility shall provide all the Alternative Care Facility services as listed at Section 8.7506, which are required by the individual respite Member.

4. HCBS Supported Living Services (SLS) Waiver

a. Respite may be provided in the Member's home;

b. The private residence of a respite care provider; or

c. In the community.

8.7545.D Adult Respite Exclusions and Limitations

1. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver

a. An individual Member shall be authorized for no more than (30) days of respite care in each support plan year unless otherwise authorized by the Department.

b. Alternative care facilities shall not admit individuals for respite care who are not appropriate for alternative care facility placement, as specified at 8.7506.

c. Only those portions of the facility that are Medicaid certified for nursing facility or alternative care facility services may be utilized for respite Members.

2. HCBS Brain Injury (BI) Waiver

a. An individual Member shall be authorized for no more than a cumulative total of 30 days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home and in a nursing facility.

i. A mix of delivery options is allowable if the aggregate amount of services is less than 30 days, or 720 hours, of respite care.

ii. In-home respite is limited to no more than eight hours per day.

iii. Nursing facility respite is billed on a per diem.

iv. Only those portions of the facility that are Medicaid certified for nursing facility services may be utilized for respite Members.

3. HCBS Supported Living Services (SLS) Waiver

a. Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.

b. Respite shall be reimbursed according to a unit rate or daily rate, whichever results in lesser reimbursement.

c. The total amount of respite days provided in one support plan year may not exceed thirty (30) days.

8.7545.E Adult Respite Provider Agency Requirements

1. HCBS Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver

a. Respite care standards and procedures for nursing facilities are as follows:

i. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. The contract shall constitute automatic Certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

ii. The nursing facility does not have to maintain or hold open separately designated beds for respite Members but may accept respite Members on a bed available basis.

iii. For each HCBS-BI/EBD/CIH/CMHS respite Member, the nursing facility must provide an initial nursing Assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the Member. The chart shall identify the Member as a respite Member. If the respite stay is for 14 days or more, the Minimum Data Set (MDS) shall be completed.

iv. An admission to a nursing facility under HCBS-BI/EBD/CIH/CMHS respite does not require a new Level of Care Screen, Pre-Admission Screening and Resident Review (PASRR) review, an AP-5615 form, a physical, a dietitian Assessment, a therapy Assessment, or lab work as required on an ordinary nursing facility

admission. The MDS does not have to be completed if the respite stay is shorter than 14 days.

v. The nursing facility shall have written policies and procedures available to staff regarding respite care Members. Such policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care Members.

vi. The nursing facility shall obtain a copy of the Level of Care Screen and the approved Prior Authorization Request (PAR) form from the Case Manager prior to the respite Member's entry into the facility.

b. Respite care standards and procedures for alternative care facilities are as follows:

i. The alternative care facility shall have a valid contract with the Department as a Medicaid certified HCBS-EBD/CMHS Alternative Care Facility Provider Agency. Such contract shall constitute Certification for HCBS-BI/EBD/CIH/CMHS respite care.

ii. For each respite care Member, the Alternative Care Facility shall follow normal procedures for care planning and documentation of services rendered.

c. Individual respite care providers shall be employees of certified personal care agencies. Family Members providing respite services shall meet the same competency standards as all other providers and be employed by the certified Provider Agency.

2. HCBS Brain Injury (BI) Waiver

a. Respite care standards and procedures for nursing facilities are as follows:

i. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. The contract shall constitute automatic Certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

ii. The nursing facility does not have to maintain or hold open separately designated beds for respite Members but may accept respite Members on a bed available basis.

iii. For each HCBS-BI/EBD/CIH/CMHS respite Member, the nursing facility must provide an initial nursing assessment, which will serve

as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the Member. The chart must identify the Member as a respite Member. If the respite stay is for 14 days or longer, the MDS must be completed.

iv. An admission to a nursing facility under HCBS-BI/EBD/CIH/CHMS respite does not require a Level of Care Screen, a Pre-Admission Screening and Resident Review (PASRR) review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than 14 days.

v. The nursing facility shall have written policies and procedures available to staff regarding respite care Members. The policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care Members.

vi. The nursing facility shall obtain a copy of the Level of Care Screen and the approved Prior Authorization Request (PAR) form from the Case Manager prior to the respite Member's entry into the facility.

b. Individual respite care providers shall be employees of certified personal care agencies. Family Members providing respite services shall meet the same competency standards as all other providers and be employed by the certified Provider Agency

8.7545.F Adult Respite Provider Reimbursement Requirements

1. For the HCBS Brain Injury (BI); Elderly, Blind, and Disabled (EBD); Complementary and Integrative Health (CIH); and Community Mental Health Supports (CMHS) Waivers:

   a. Respite care reimbursement to nursing facilities shall be as follows:

      i. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-BI/EBD/CIH/CMHS claim form according to fiscal agent instructions.

      ii. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four-hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

iii. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

iv. Respite care reimbursement to Alternative Care Facilities shall be as follows:

1) The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four-hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

v. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

b. Individual respite providers shall bill according to a unit rate or daily institutional Nursing Facility rate, whichever is less.

c. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI/EBD/CIH/CMHS services shall not be reimbursed during the respite stay.

d. There shall be no reimbursement provided under this section for respite care in Uncertified Congregate Facilities.

2. HCBS Supported Living Services (SLS) Waiver:

a. Respite shall be provided according to individual, overnight group, or group rates as defined below:

i. Individual: the Member receives respite in a one-on-one situation. There are no other Members in the setting also receiving respite services.

ii. Overnight Group: the Member receives respite in a setting which is defined as a facility that offers 24-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.

iii. Group: the Member receives care along with other individuals, who may or may not have a disability. The total cost of the group rate within a 24-hour period shall not exceed the respite daily rate.

8.7546 Child Respite

8.7546.A Child Respite Eligibility

1. Child Respite is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Children with Complex Health Needs Waiver

    b. Children's Extensive Support Waiver

    c. Children's Habilitation Residential Program

8.7546.B Child Respite Definition

1. Child Respite care means services provided to an eligible Member on a short-term basis because of the absence or need for relief of those persons who normally provide the care.

2. Unskilled Respite means services provided to an eligible Member by a trained and unlicensed support staff.

3. Skilled Respite means services provided to an eligible Member by a licensed RN/LPN/or CNA. These services must qualify as skilled care as prescribed by a Licensed Medical Professional.

4. Therapeutic Respite means services provided to an eligible Member by a specially-trained and certified support provider for ongoing behavioral support needs.

8.7546.C Child Respite Inclusions

1. HCBS Children's Extensive Supports (CES) Waiver

    a. Respite may be provided in the Member home or private residence;

    b. The private residence of a respite care provider; or

    c. In the community.

2. HCBS Children with Complex Health Needs (CwCHN) Waiver

    a. Respite care may be provided in the home;

    b. In the community; or

    c. In an approved respite center location of a Member.

3. HCBS Children's Habilitation Residential Program Waiver (CHRP) Waiver

a. Respite services may be provided in a Certified Foster Care Home;

b. Kinship Foster Care Home;

c. Licensed Residential Child Care Facility;

d. Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours);

e. in the Family home; or

f. or in the community.

g. Overnight out of home Respite must be in a Foster Care Home, Kinship Home, Group Home, or Residential Child Care Facility (RCCF).

8.7546.D Child Respite Exclusions and Limitations

1. HCBS Children's Extensive Supports (CES) Waiver

a. Respite is to be provided in an age-appropriate manner. Respite is not a covered benefit for Member 11 years of age and younger during the time the primary caregiver is at work, pursuing continuing education or engaging in volunteer activities.

b. When the cost of care during the time the caregiver at work is more for a Member 11 years of age or younger, than it is for same age peers, respite may be used to pay the difference in costs. Caregivers shall be responsible for the basic and typical costs of childcare.

2. HCBS Children with Complex Health Needs (CwCHN) Waiver

a. Respite care shall not be provided at the same time as Home Health or Palliative/Supportive Care services.

8.7546.E Child Respite Provider Reimbursement Requirements

1. HCBS Children's Extensive Supports (CES) Waiver

a. Respite shall be provided according to an individual or group rates as defined below: Individual: the Member receives respite in a one-on-one situation. There are no other Members in the setting also receiving respite services.

b. Unskilled Individual day: the Member receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24-hour period.

c. Skilled and Therapeutic Individual day: the Member receives respite in a one-on-one situation for cumulatively more than four hours in a 24-hour period. A full day is four hours or greater within a 24-hour period.

d. Overnight group: the Member receives respite in a setting which is defined as a facility that offers twenty-four (24) hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty-four (24) hour period shall not exceed the respite daily rate.

e. Group: the Member receives care along with other individuals, who may or may not have a disability. The total cost of the group rate within a twenty-four (24) hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:

f. The total amount of respite provided in one support plan year may not exceed an amount equal to 30 day units and 1,880 15-minute units. The Department may approve a higher amount based on a need due to a documented increase in medical or behavioral needs.

g. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or other services not covered by the HCBS-CES waiver.

h. Respite shall be reimbursed according to a unit rate or daily rate, whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.

i. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a Member. Additional respite units beyond the service limit will not be approved for Members who receive skilled nursing, certified nurse aide services, personal care, homemaker, health maintenance activities, or home care allowance from the primary caregiver.

j. Respite may not be provided by the Member’s legal guardian, primary caregiver, or Legally Responsible Person.

2. HCBS Children with Complex Health Needs (CwCHN) Waiver

    a. Respite is not to exceed thirty (30) days per support plan year, as determined by the Department approved assessment. The Department may approve a higher amount based on a need due to a documented increase in medical or behavioral needs.

    b. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a Member. Additional respite units beyond the service limit will not be approved for Members who receive skilled nursing, certified nurse aide services, personal care, homemaker, health maintenance activities, or home care allowance from the primary caregiver.

    c. Respite may not be provided by the Member's Legal Guardian, primary caregiver, or a Legally Responsible Person.

3. HCBS Children's Habilitation Residential Program Waiver (CHRP) Waiver

    a. Respite is provided at an individual or group rate, defined as follows: Individual: the Member receives respite in a one-on-one situation. There are no other Members receiving respite at the same time in the same setting. Group: the Member receives respite with other individuals, who may or may not have a disability. The total cost services provided in a group setting must not exceed the respite daily rate.

    b. The total amount of respite provided in one support plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units, where one unit is equal to 15 minutes. The Department may approve a higher amount when needed due to a documented increase in medical or behavioral needs.

    c. During the time when Respite is occurring, the Foster Care or Kinship respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.

    d. Respite is available for children or youth living in the Family home and may not be utilized while the Member is receiving Habilitation services.

    e. Overnight group respite may not substitute for other services provided by the provider such as Behavioral Services or other services not covered by the HCBS-CHRP waiver.

    f. Respite shall be reimbursed according to a unit rate or daily rate, whichever is less.

g. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a Member. Additional respite units beyond the service limit will not be approved for Members who receive skilled nursing, certified nurse aide services, personal care, homemaker, home maintenance activities, or home care allowance from the primary caregiver.

h. Respite may not be provided by the Member's Legal Guardian, primary caregiver, or a Legally Responsible Person.

8.7547 Specialized Medical Equipment and Supplies

8.7547.A Specialized Medical Equipment and Supplies Eligibility

1. Specialized Medical Equipment and Supplies (SMES) is a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a. Brain Injury Waiver

   b. Children's Extensive Support Waiver

   c. Developmental Disabilities Waiver

   d. Supported Living Services Waiver

8.7547.B Specialized Medical Equipment and Supplies Definition

1. Specialized Medical Equipment and Supplies means devices, controls, or appliances that help the Member perceive, control, or communicate with their environment to increase their ability to perform Activities of Daily Living or remain safely in their home and community.

8.7547.C Specialized Medical Equipment and Supplies Inclusions

1. Specialized Medical Equipment and Supplies is authorized for Organized Health Care Delivery System (OHCDS).

2. Specialized Medical Equipment and Supplies include devices, controls, or appliances that help the Member perceive, control, or communicate with their environment to increase their ability to perform Activities of Daily Living or remain safely in their home and community.

3. Devices, controls or appliances that enable the Member to increase their ability to perform Activities of Daily Living,

4. Devices, controls or appliances that enable the Member to perceive, control or communicate within their environment,

5. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

6. Durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to Member's needs assessed in the Person-Centered Support Plan;

7. Necessary medical supplies in excess of Medicaid State Plan limitations or not available under the Medicaid State Plan.

8. Maintenance and upkeep of specialized medical equipment purchased through the HCBS waiver.

9. All items shall meet applicable standards of manufacture, design and installation.

10. HCBS Supported Living Services Waiver, Children's Extensive Supports Waiver

    a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

    b. Specially designed clothing for a Member if the cost is over and above the costs generally incurred for a Member's clothing.

8.7547.D Specialized Medical Equipment and Supplies Exclusions and Limitations

1. Specialized Medical Equipment and Supplies excludes those items that are not of direct medical or remedial benefit to the Member as assessed through their Person-Centered Support Plan.

2. Durable and non-durable medical equipment available under the Medicaid State Plan

3. Items that are not of direct medical or remedial benefit to the Member include vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items and wipes for any purpose other than incontinence are not covered under this service.

8.7548 Substance Use Counseling

8.7548.A Substance Use Counseling Eligibility

1. Substance Use Counseling is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.7548.B Substance Use Counseling Definition

1. Substance Use Counseling services shall be designed to support the Member in managing and/or overcoming substance use. These services are in addition to counseling services available through State Plan services and are not intended to replace these services.

8.7548.C Substance Use Counseling Inclusions

1. Outpatient individual, group, and Family counseling services may be provided in the home, community, or provider's office.

2. Substance abuse services are provided in a non-residential setting and must include Assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver Member, Family or caregivers when appropriate, periodic Reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, Family counseling for persons if directly involved in the support system of the Member, interdisciplinary care coordination meetings, and an aftercare plan staffed with the Case Manager.

3. Counseling services are limited to 30 units of individual, group, family, or a combination of counseling services. The Department may authorize additional units based on needs identified in the Person-Centered Support Plan or care plan.

8.7548.D Substance Use Counseling Exclusions and Limitations

1. Inpatient treatment is not a covered benefit.

8.7548.E Substance Use Counseling Provider Agency Requirements

1. Substance abuse services may be provided by any Provider Agency or individual licensed by the Behavioral Health Administration (BHA) and certified by the Department of Health Care Policy and Financing (HCPF).

2. Providers must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to Members with substance abuse problems. The provider shall promote training to improve the ability of the community resources to provide ongoing support to Members living with a Brain Injury.

3. Counselors shall be certified at the Certified Addiction Specialist, Licensed Addictions Counselor level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any Member with a Brain Injury or their Family Members.

8.7548.F Substance Use Counseling Reimbursement

1. There are three separate counseling services allowable under HCBS-BI counseling services including Family Counseling (if the Member is present), Individual Counseling, and Group Counseling each reimbursed on a 1 unit = 1 hour basis

8.7549 Supported Employment

8.7549.A Supported Employment Service Eligibility

1. Supported Employment is a covered benefit available to Members enrolled in one of the following HCBS waivers:

    a. Developmental Disabilities Waiver

    b. Supported Living Services Waiver

8.7549.B Supported Employment Service Definition

1. Supported Employment services are services provided to Members who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive employment, customized employment, or self-employment. The outcome of this service shall be sustained paid employment in a job that meets personal and career goals. The job shall be in an integrated setting in the general workforce and must be compensated at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Covered Supported Employment services include Job Development, Job Placement, Job Coaching, and Workplace Assistance.

8.7549.C Supported Employment Service Inclusions

1. Supported Employment may include assessment and identification of vocational interests and capabilities in preparation for job development and assisting the Member to locate a job or job development on behalf of the Member.

2. Supported Employment may be delivered in a variety of settings in which Members have the opportunity to interact regularly with individuals without disabilities, other than those individuals who are providing services to the Member.

3. Supported Employment shall support Members in achieving sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

4. Group Employment services (e.g. mobile crews) shall be available to a small group two to eight persons and shall be provided in community business and industry settings.

5. Supported Employment is work outside of a facility-based site, which is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities.

6. Supported Employment includes activities needed to sustain paid work by Members including supervision and training.

7. If a Member is employed, the supervision the Member needs while at work shall be clearly documented in their Person-Centered Support Plan. A Member's supervision level at work must be based on the Member's specific work-related support needs.

    a. The level of supervision by paid caregivers may be lower at work than in other community settings without impacting the Level Of Care (LOC), and the Member shall not be over-supported or limited in their ability to work based on supervision needs identified for other settings.

8.7549.D Supported Employment Service Access and Authorizations

1. Documentation is maintained in the file of each Member receiving this service that the type of employment related support the Member needs is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.)

2. Supported Employment services, in combination with Day Habilitation and Prevocational services are limited to 7,112 units per support plan year. One unit equals 15 minutes of service.

8.7549.E Supported Employment Service Exclusions and Limitations

1. Supported Employment services do not include payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business.

2. Supported Employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

3. Supported Employment shall not take the place of nor shall it duplicate services received through the Division for Vocational Rehabilitation.

4. The following are not a benefit of Supported Employment and shall not be reimbursed:

    a. Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment;

    b. Payments that are distributed to users of Supported Employment; and

c. Payments for training that are not directly related to a Member's Supported Employment.

8.7549.F Supported Employment Service Provider Agency Requirements

1. Supported Employment service providers, including Supported Employment professionals who provide individual Competitive Integrated Employment, as defined in 34 C.F.R. § 361.5(c)(9) (2023), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and Certification requirements.

2. Reimbursement for Supported Employment services training is subject to the availability of appropriations in Section 8.7549.G. Provider Agencies must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment Certification (Certification).

3. Deadlines.

   a. Existing staff employed by the Provider Agency on or before July 1, 2019 must obtain a Training Certificate or a Certification no later than July 1, 2024.

   b. Newly hired staff, employed by the Provider Agency after July 1, 2019 must obtain a Training Certificate or a Certification no later than July 1, 2024.

   c. Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

4. Department approval required.

   a. The Training Certificate or Certification required under Section 8.7549.F.2 must be pre-approved by the Department. Provider Agencies must submit the following information to the Department for pre-approval review:

      i. Provider name.

      ii. A current Internal Revenue Service Form W-9.

      iii. Whether the Provider is seeking approval for:

         1) Training Certificate, or

         2) Certification, or

3) Training Certificate and Certification.

iv. Description of training, if applicable, including:

1) Number of staff to be trained.

2) Documentation that the training is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

v. Description of Certification, if applicable, including:

1) Number of staff to receive Certification.

2) Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

vi. Dates of training, if applicable, including whether a certificate of completion is received.

vii. Date of Certification exam, if applicable.

b. Department approval of a Training Certificate Curriculum will be based on alignment with the following core competencies:

i. Core values and principles of Supported Employment, including the following:

1) All people are capable of full participation in employment and community life. The preferred outcome for all working age persons with disabilities is employment.

ii. The Person-Centered process, including the following:

1) The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-Centered approach includes working with a team where the individual chooses the people involved on the team and receives necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.

iii. Individualized career assessment and planning, including the following:

1) The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.

iv. Individualized job development, including the following:

1) Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.

v. Individualized job coaching, including the following:

1) Providing necessary workplace supports to Members with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.

vi. Job Development, including the following:

1) Effectively engaging employers for the purpose of community job development for Members with significant disabilities, which meets the needs of both the employer and the Member

c. The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and notify the Provider of its determination within 30 days of receiving the pre-approval request under Section 8.7549.F.4.a.

8.7549.G Supported Employment Provider Reimbursement Requirements

1. Reimbursement for a Supported Employment Training Certificate or Certification, or both, which includes both the cost of attending a training or obtaining a Certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse Provider Agencies for such costs.

a. Providers seeking reimbursement for completed training or Certification, or both, approved pursuant to Section 8.7549.F.4., must submit the following to the Department:

i. Supported Employment providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or Certifications, except for trainings and Certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or Certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

1) Reimbursement requests must include documentation of successful completion of the training or Certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving a reimbursement request pursuant to Section 8.7549.G.1.a.i, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification as required by Section 8.7549.F.4,c and either notify the provider of the denial or, if approved, reimburse the provider.

a. Reimbursement is limited to the following amounts and includes reimbursement for wages:

i. Up to $300 per Certification exam.

ii. Up to $1,200 for each training.

8.7550 Supported Living Program

8.7550.A Supported Living Program Eligibility

1. Supported Living Program is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver

8.7550.B Supported Living Program Definitions

1. The Supportive Living Program (SLP) means an Assisted Living Residence as defined at 6 C.C.R. 1011-1, Chapter VII, Section 2, which has been licensed by the Colorado Department of Public Health and Environment (CDPHE) and has been certified by the Department to provide Supportive Living Program services to Medicaid Members. The Supportive Living Program is a specialized assisted living service for Members with brain injuries. Settings are certified. Services include 24-hour oversight, Assessment, training and supervision of self-care, medication management, behavioral management, and cognitive supports. They also include interpersonal and social skills development.

8.7550.C Supported Living Program Inclusions

1. Supportive Living Program services consist of structured services designed to provide:

    a. Assessment;

    b. Protective Oversight and supervision as defined at Section 8.7506.B.2;

    c. Behavioral Management and Education;

    d. Independent Living Skills Training in a group or individualized setting to support:

        i. Interpersonal and social skill development;

        ii. Improved household management skills; and

        iii. Other skills necessary to support maximum independence, such as financial management, household maintenance, recreational activities and outings, and other skills related to fostering independence.

    e. Community Participation;

    f. Transportation between therapeutic activities in the community;

    g. Activities of Daily Living (ADLs);

    h. Personal Care and Homemaker services; and

    i. Health Maintenance Activities.

    j. The Supportive Living Program provider shall ensure that each Member is furnished with their own personal hygiene and care items. These items are to be considered basic in meeting a Member's need for hygiene and remaining healthy. Any additional items may be selected and purchased by the Member at their discretion.

2. Servic Planning

    a. Supportive Living Program Provider Agencies must comply with the Person-Centered Support Planning process. Providers must work with Case Management agencies to ensure coordination of a Member’s Person-Centered Support Plan and Provider Care Plan. Additionally, Supportive Living Program providers must provide the following actionable plans for all Brain Injury (BI) waiver Members, updated every six (6) months:

        i. Transition Planning; and

ii. Goal Planning.

b. These elements of a care plan are intended to ensure the Member actively engages in their care and activities and is able to transition to any other type of setting or service when desired.

8.7550.D Supported Living Program Exclusions and Limitations

1. The following are not included as components of the Supportive Living Program:

a. Room and board shall not be a benefit of Supportive Living Program services, as set forth at Section 8.7413.

b. Additional services which are available as a State Plan benefit or other Brain Injury waiver service. Examples include, but are not limited to physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, long-term home health, and private duty nursing.

8.7550.E Supported Living Program Provider Agency Requirements

1. Staffing

a. The Supportive Living Program Provider Agency shall ensure sufficient staffing levels to meet the needs of Members.

b. The operator, staff, and volunteers who provide direct Member care or Protective Oversight as defined at 8.7506.B.2 must be trained in precautions and emergency procedures, including first aid, to ensure the safety of the Member. Within one month of the date of hire, the Supportive Living Program Provider Agency shall provide adequate training for staff on each of the following topics:

i. Crisis prevention;

ii. Identifying and dealing with difficult situations;

iii. Cultural competency;

iv. Infection control; and

v. Grievance and Complaint procedures.

c. In addition to the requirements of 6 C.C.R. 1011-1 Ch. 7, the Department requires that the program director shall have an advanced degree in a health or human service-related profession plus two years of experience providing direct services to persons with a Brain Injury. A bachelor's or

nursing degree with three years of similar experience, or a combination of education and experience shall be an acceptable substitute.

d. The Supportive Living Program shall ensure that provision of services is not dependent upon the use of Members to perform staff functions. Volunteers may be utilized in the home but shall not be included in the Provider Agency's staffing plan in lieu of employees.

2. Environmental and Maintenance Requirements

a. Supportive Living Program providers shall develop and implement procedures for the following:

i. Handling of soiled linen and clothing;

ii. Storing personal care items;

iii. General cleaning to minimize the spread of pathogenic organisms; and

iv. Keeping the home free from offensive odors and accumulations of dirt and garbage.

8.7550.F Supported Living Program Provider Reimbursement Requirements

1. Room and board shall not be a benefit of Supportive Living Program services.

2. Supportive Living Program services shall be reimbursed according to a tiered per diem rate based on Member acuity, using a methodology determined by the Department.

3. Supportive Living Program services are subject to Post Eligibility Treatment of Income (PETI), as described in 8.7202.BB.

8.7551 Therapeutic Life Limiting Illness Support

8.7551.A Therapeutic Life Limiting Illness Support Eligibility

1. Therapeutic Life Limiting Illness Support is a covered benefit available to Members enrolled in the HCBS Children with Complex Health Needs Waiver.

8.7551.B Therapeutic Life Limiting Illness Support Definition

1. Therapeutic Life Limiting Illness Support is intended to help the Member and Family in the disease process. Support is provided to the Member to decrease emotional suffering due to health status and develop coping skills. Support is provided to the Member and/or Family Members in order to guide and help them cope with the Member's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child.

8.7551.C Therapeutic Life Limiting Illness Support Inclusions, Exclusions and Limitations

1. Support includes but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the Family with community resources such as funding or transportation.

2. Therapeutic Life Limiting Illness Support may be provided in individual or group settings.

3. Therapeutic Life Limiting Illness Support shall only be a benefit if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

4. Therapeutic Life Limiting Illness Support is limited to the Member's assessed need up to a maximum of 98 hours per annual certification period.

8.7551.D Therapeutic Life Limiting Illness Support Provider Requirements

1. Individuals providing Therapeutic Life Limiting Illness Support shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice Agency.

2. Individuals providing Therapeutic Life Limiting Illness Support shall be one of the following:

    a. Licensed Clinical Social Worker (LCSW)

    b. Licensed Professional Counselor (LPC)

    c. Licensed Social Worker (LSW)

    d. Licensed Independent Social Worker (LISW)

    e. Licensed Psychologist; or

3. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice Agency.

8.7552 Transition Setup

8.7552.A Transition Setup Eligibility

1. Transition Setup is a covered benefit available to Members enrolled in CFC.

8.7552.B Transition Setup Definition

1. Transition Setup care means coordination and coverage of one-time, non-recurring expenses necessary for a Member to establish a basic household upon transitioning from a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to a community living arrangement that is not operated by the State.

8.7552.C Transition Setup Inclusions

1. Transition Setup assists the Member by coordinating the purchase of items or services needed to establish a basic household and to ensure the home environment is ready for move-in with all applicable furnishings set up and operable; and

2. Transition Setup allows up to $2000 in reimbursement for the purchase of one-time, non-recurring expenses necessary for a Member to establish a basic household as they transition from an institutional setting to a community setting. The Department may authorize additional funds above the $2,000 limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member. Allowable expenses include:

    a. Security deposits that are required to obtain a lease on an apartment or home.

    b. Setup fees or deposits to access basic utilities or services (telephone, internet, electricity, heat, and water).

    c. Services necessary for the individual’s health and safety such as pest eradication or one-time cleaning prior to occupancy.

    d. Essential household furnishings required to occupy, including furniture, window coverings, food preparation items, or bed or bath linens.

    e. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.

    f. Housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal background check.

8.7552.D Transition Setup Service Access and Authorization

1. To access Transition Setup, a Member must be transitioning from an institutional setting or Regional Center to a community living arrangement and participate in a needs-based Assessment through which they demonstrate a need for the service based on the following:

a. The Member demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a Member to establish a basic household in the community;

b. The need demonstrates risk to the Member's health, safety, or ability to live in the community; or

c. Other services/resources to meet need are not available.

2. The Member 's assessed need must be documented in the Member 's Transition Plan and Person-Centered Support Plan.

8.7552.E Transition Setup Exclusions and Limitations

1. Transition Setup may be used to coordinate or purchase one-time, non-recurring expenses up to thirty (30) days post-transition.

2. Transition Setup does not substitute for services available under the Medicaid State Plan, other Waiver Services, or other resources.

3. Transition Setup is not available to a Member transitioning to, or residing in, a provider-owned or provider-controlled setting.

4. Transition Setup does not include payment for room and board.

5. Transition Setup does not include rental or mortgage expenses, ongoing food costs, regular utility charges, cable or satellite services.

6. Transition Setup is not available for a transition to a living arrangement that does not match or exceed HUD certification criteria.

7. Transition Setup does not include appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television, gaming, or video equipment).

8.7552.F Transition Setup Provider Agency Requirements

1. The Provider Agency shall ensure all products and services delivered to the Member shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

8.7552.G Transition Setup Documentation

1. The Provider Agency must maintain receipts for all services and/or items procured for the Member. These must be attached to the claim and noted on the Prior Authorization Request.

2. Provider Agencies must submit to the Case Management Agency the minimum documentation of the transition process, which includes:

a. A Transition Services Referral Form,

b. Release of Information (confidentiality) Forms, and

c. A Transition Setup Authorization Request Form.

3. The Provider Agency must furnish to the Member a receipt for any services or durable goods purchased on the Member's behalf.

8.7552.H Transition Setup Provider Agency Reimbursement

1. Transition Setup Coordination is reimbursed according to the number of units billed, with one unit equal to 15-minutes of service. The maximum number of Transition Setup units eligible for reimbursement is 40 units per eligible Member.

2. Transition Setup Expenses must not exceed $2000 per eligible Member. The Department may authorize additional funds above the $2000 limit, up to $2,500, when the Member demonstrates additional needs, and if the expense(s) would ensure the Member's health, safety and welfare.

3. Reimbursement shall be made only for items or services described in the Provider Care Plan with accompanying receipts.

4. When Transition Setup is furnished to individuals returning to the community from an institutional setting through enrollment in a waiver, the costs of such services are billable when the person leaves the institutional setting and is enrolled in the waiver.

8.7553 Transitional Living Program

8.7553.A Transitional Living Program Eligibility

1. Transitional living Program is a covered benefit available to Members enrolled in the HCBS Brain Injury Waiver.

8.7553.B Transitional Living Program Definition

1. The Transitional living Program is a residential service designed to improve the Member's ability to live in the community by provision of 24-hour services, support and supervision.

8.7553.C Transitional Living Program Inclusions

1. All services must be documented in an approved plan of care and be prior authorized by the Department.

2. Program services include but are not limited to Assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication

management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household.

3. Extraordinary therapeutic needs mean, for purposes of this program, a Member who requires more than three hours per day of any combination of therapeutic disciplines. This includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

8.7553.D Transitional Living Program Exclusions and Limitations

1. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this Level of Care. If a Member requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for the Transitional Living Program service for a Member must be documented and authorized individually by the Department.

2. Transportation between therapeutic tasks in the community, recreational outings, and Activities of Daily Living is included in the per diem reimbursement rate and shall not be billed as separate charges.

3. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.

4. Room and board shall not be a benefit of Transitional Living Program services, set forth at Section 8.7414.

5. Items of personal need or comfort shall be paid out of money set aside from the Member's income and accounted for in the determination of Financial Eligibility for the Brain Injury program.

6. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the Department.

8.7553.E Transitional Living Program Provider Agency Requirements

1. Policies

   a. The Provider Agency shall confirm that Members must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

   b. The Provider Agency shall inform Members and Legally Authorized Representatives of the inherent risk associated with participation in a

community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

c. The Provider Agency shall confirm that Members need available assistance in a congregate setting for safety and supervision and require support in meeting psychosocial needs.

d. The Provider Agency shall confirm that Members require available paraprofessional nursing assistance on a 24-hour basis due to dependence in Activities of Daily Living, locomotion, or cognition.

e. Understanding that Members of transitional living programs frequently experience behavior which may be a danger to themselves or others, the Provider Agency shall ensure the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The Provider Agency shall have written agreements with other providers in the community who may provide short term Crisis intervention to provide a safe and secure environment for a Member who is experiencing severe behavioral difficulties, or who is actively homicidal or suicidal.

f. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve Members for whom they lack adequate resources to ensure safety of program Members and staff.

g. Upon entry into the program, discharge planning shall begin with the Member and family. Transitional living programs shall work with the Member and Case Manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living program services.

h. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

i. During daytime hours, 7:00 am to 7:00 pm, the ratio of staff to Members shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.

j. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Department.

2. Training

a. At a minimum, the program director shall have an advanced degree in a health or human service-related profession plus three years of experience providing direct services to Members with a Brain Injury. A bachelor's degree with five years of experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.

b. Transitional living programs shall demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the Member. These staff Members shall have successfully completed a training program of at least 40 hours duration.

c. Transitional living Program Provider Agencies must satisfactorily complete an introductory training course on Brain Injury and rules and regulations pertaining to transitional living centers prior to Certification of the Transitional living Program.

d. The provider, staff, and volunteers who provide direct Member care or Protective Oversight as defined at 8.7506.B.2 must be trained in first aid Universal Precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Transitional living Program's certified prior to the effective date of these rules shall have 60 days to satisfy this training requirement.

e. Training in the use of Universal Precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Transitional living Program's certified prior to the effective date of these rules shall have 60 days to satisfy this training requirement.

f. Staffing of the program must include at least one individual per shift who has Certification as a medication aide prior to assuming responsibilities.

8.7553.F Transitional Living Program Provider Reimbursement Requirements

1. Room and board shall not be a benefit of Transitional living Program services.

2. Transitional living Program services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.

8.7554 Vehicle Modifications

8.7554.A Vehicle Modifications Eligibility

1. Vehicle Modifications is a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a. Children's Extensive Support Waiver

b. Supported Living Services Waiver

8.7554.B Vehicle Modifications Definition

1. Vehicle Modifications means adaptations or alterations to an automobile that are:

   a. The Member's primary means of transportation.

   b. To accommodate the needs of the Member, as a result of the Member's disability and shall not be approved if the need is a typical age-related need.

   c. Are necessary to enable the Member to integrate more fully into the community and to ensure the health and safety of the Member.

8.7554.C Vehicle Modifications Inclusions

1. Vehicle Modifications is authorized for Organized Health Care Delivery System (OHCDS).

2. Upkeep and maintenance of the modifications to the vehicle are allowable services.

8.7554.D Vehicle Modifications Exclusions and Limitations

1. Items and services specifically excluded from reimbursement under the HCBS waivers include:

   a. Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the Member;

   b. Purchase or lease of a vehicle; and

   c. Typical and regularly scheduled upkeep and maintenance of a vehicle.

8.7554.E Vehicle Modifications Case Management Agencies Responsibilities

1. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed 10,000 dollars over the five (5) year life of the HCBS waiver without an exception granted by the Department:

   a. The Case Manager may approve Vehicle Modifications when the total cumulative cost is under $10,000 for the cost of Home Modifications, Vehicle Modifications and Assistive Technology.

   b. For modifications with a cumulative total over $10,000, the Case Manager shall obtain approval by submitting a request to the Department.

i. The Case Manager shall obtain all supporting documentation according to department prescribed processes and procedures.

ii. An occupational or physical therapist (OT/PT) shall assess the Member's needs and the therapeutic value of the requested Vehicle Modification. When an OT/PT with experience in Vehicle Modification is not available, a qualified individual may be substituted, with Department approval.

iii. The Case Manager shall obtain at least two bids for the necessary work. If the Case Manager has made three attempts to obtain a written bid from a Provider Agency and the Provider Agency has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid.

2. Requests for costs that exceed a Member's cumulative allotment of $10,000 over the five-year life of the HCBS waiver may be approved by the Department if it:

   a. Ensures the health and safety of the Member;

   b. Enables the Member to function with greater independence within the community ; or

   c. Decreases the need for paid assistance in another HCBS waiver service on a long-term basis.

3. Case Management Agency approval for a higher amount shall include a thorough review of the current request as well as past expenditures to ensure cost effectiveness, prudent purchases and no unnecessary duplication.

8.7554.F Vehicle Modifications Provider Agency Reimbursement

1. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 dollars over the five year life of the HCBS waiver without an exception granted by the Department.

2. Vehicle Modifications that have been completed prior to approval will not be reimbursed.

8.7555 Vision Services

8.7555.A Vision Services Eligibility

1. Vision services is available to Members enrolled in one of the following HCBS waivers:

   a. Developmental Disabilities Waiver

b. Supported Living Services Waiver

8.7555.B Vision Services Inclusions

1. Vision Services is authorized for Organized Health Care Delivery System (OHCDS).

2. HCBS Developmental Disabilities (DD) Waiver; Supported Living Services (SLS) Waiver

   a. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a Member who is at least twenty-one (21) years of age.

   b. Lasik and other similar types of procedures are only allowable when:

      i. The procedure is necessary due to the Member's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and

      ii. Prior authorized in accordance with Department procedures.

8.7556 Wellness Education Benefit

8.7556.A Wellness Education Benefit Eligibility

1. Wellness Education Benefit is a covered benefit available to Members enrolled in one of the following HCBS waivers:

   a) Brain Injury Waiver

   b) Children's Extensive Support Waiver

   c) Children's Habilitation Residential Program Waiver

   d) Children's Home and Community Based Services Waiver

   e) Children with Life Limiting Illness Waiver

   f) Community Mental Health Supports Waiver

   g) Complementary and Integrative Health Waiver

   h) Developmental Disabilities Waiver

   i) Elderly, Blind and Disabled Waiver

   j) Supported Living Services Waiver

8.7556.B Wellness Education Benefit Definitions

1. Article means a written document that contains text related to health or wellness topics that a Member receives.

2. Article Topic means a health and wellness topic that relates to helping a Member manage health-related issues, achieve goals on their Person-Centered Support Plan, and address topics of community living.

3. Mail means the mechanism by which the benefit is sent to the Member through the United States Postal Service.

4. Plain language means friendly and clear, with a direct, conversational tone and active voice. The information is organized in logical order for the reader. Paragraphs are one-topic and brief, and sentences are simple and short. Plain language includes using common, everyday vocabulary consistently across correspondence, with few multi-syllable words and few technical or bureaucratic words.

5. Service rendered means the Provider Agency has sent the Wellness Education Benefit.

6. Provider Agency means the entity contracted with the Department to distribute the Wellness Education Benefit.

7. Verified Address means an address that mail can be sent to and received by a Member.

8. Wellness Education Benefit is individualized educational materials designed to reduce the need for a higher level of care by offering educational materials that provide members and their families with actionable tools that can be used to prevent the progression of a disability, increase community engagement, combat isolation, and improve awareness of Medicaid services. The Wellness Education Benefit helps Members and their unpaid caregivers to obtain, process, and understand information that assists with managing health-related issues, promoting community living, and achieving goals identified in their Person-Centered Support Plans. Wellness Education Benefit services include varied topics such as engaging in community activities, nutrition, adaptive exercise, balance training and fall prevention, money management, and developing social networks.

8.7556.C Wellness Education Benefit Inclusions

1. The Wellness Education Benefit shall be delivered to the Member's mailing address in a printed format.

2. Article topics can provide the information needed to: Navigate the Medicaid/medical system to achieve better health outcomes, successfully

manage chronic conditions in order to decrease risk of nursing facility placement, effectively communicate health and wellness goals, effectively communicate with medical and social service professionals, provide unpaid caregivers with relevant information regarding best practices around support and care of the Member, achieve community living goals identified in the Person-Centered Support Plan by providing simple, actionable suggestions to help support the health and welfare of waiver Members.

3. Article topics shall be written in plain language.

4. The Wellness Education Benefit is delivered no less than once every month, with a maximum of 12 unique education materials per certification period.

5. Wellness Education Benefit shall be provided in a format that is accessible to the Member at the request of the Member and their support team including, but not limited to, preferred written language. For Members who cannot read standard print and would benefit from an alternative format, educational materials will be sent to Members in the requested accessible format, which may include larger print or braille.

8.7556.D Wellness Education Benefit Restrictions and Exclusions

1. Additional wellness reading materials, software, or subscriptions are excluded from the Wellness Education Benefit.

2. Article topics that do not address community living, Medicaid navigation, health-related issues, health care needs, mental health-related issues, or Person-Centered Support Plan goals shall be excluded from this benefit.

3. The Wellness Education Benefit does not duplicate services found in Early and Periodic Screening, Diagnostic, and Treatment.

8.7556.E Wellness Education Benefit Provider Requirements

1. Provider Agencies must be contracted with the Department to distribute the Wellness Education Benefit.

2. Wellness Education Benefit Provider Agency shall be responsible for the following tasks:

    a. Receive and manage member data in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) regulations and ensure client confidentiality and privacy.

    b. Translate materials into select languages, as directed by the Department.

    c. Both the Department and Wellness Benefit Provider Agency shall ensure that professionally certified translators and reviewers complete article

translations and that translations are linguistically accurate and consistent with the formatting and technical specifications of the original document. Translations will be reviewed for cultural appropriateness before delivery.

d. Ensure that materials are Person-Centered and are formatted in an accessible format, which may include Braille, large print, or high contrast formats.

e. Maintain records of articles sent to Members to prevent duplication of materials.

f. Conduct Member outreach to gather information on how the benefit has helped Members thrive in the community and meet the health and wellness goals.

g. Utilize information on the Member's Person-Centered Support Plan and updated health conditions to guide the subject matter of the educational materials.

h. Identify any undeliverable Member addresses prior to each monthly mailing and manage any returned mail by sending the Department electronic, custom-formatted relevant address information. The Department will coordinate with Case Managers to update the Member's address and send updated address to the Provider Agency.

i. Verify Member addresses data files through the United States Postal Service "National Change of Address" database and identify any addresses that are undeliverable by USPS.

i. The Department will be informed by the Wellness Education Benefit Provider Agency of the educational materials that are undeliverable or returned to sender. An attempt to deliver the following month's service will take place using the following procedure:

1) The Department will notify the Members' Case Management Agencies of any returned or undeliverable mail.

2) Case Management Agencies shall update addresses in accordance with Department guidance.

8.7556.F Wellness Education Benefit Provider Reimbursement Requirements

1. The Wellness Education Benefit is reimbursed based on the number of units of service provided, with one unit equal to one Article.

2. The Wellness Education Benefit will be delivered once every month, for twelve (12) units total in a certification period.

a. The Case Manager may authorize up to 12 additional units per support plan year for the following:

i.

ii. A Member has requested reasonable accommodation for an alternative format, such as braille.

iii. A Member requests that their representative receive a copy of the benefit to help them better utilize information provided in the benefit. Department approval required.

3. The annual total units that may be authorized for the Wellness Education Benefit shall not exceed 24 units per plan year.

8.7556.G Wellness Education Benefit Case Management Agency Responsibilities

1. Wellness Education Benefit Introduction and Education:

a. The Case Manager shall provide Member information on the benefits of the Wellness Education Benefit, the types of articles included, and the frequency of delivery.

b. Through the person-centered planning process, the Case Manager will determine a format that is accessible to the Member including, but not limited to, preferred written language.

2. Case Management Agencies shall update addresses in accordance with Department guidance.

3. The Case Manager will work with the Member to update their Person-Centered Support Plan. Goals within a Member's Person-Centered Support Plan may be utilized to determine specific Wellness Education Benefit materials that will support the member to meet those goals.

4. The Case Manager may work with the Provider Agency to ensure the educational materials are being targeted to meet any new needs the Member may have.

5. Disenrollment

a. If a Member wishes to opt out of the service, the Case Manager shall inform the Member of the possible implications of disenrollment. If a Member disenrolls, the Case Manager must revise the Prior Authorization Request to end-date the Wellness Education Benefit.

b. The Wellness Education Benefit is recognized as an HCBS service as it relates to CCR 8.7101.35 and may be utilized to maintain waiver eligibility.

c. If services are decreased without the Member's agreement, the Case Manager shall notify the Member of the adverse action and of appeal rights, according to Long-Term Care Waiver Program Notice of Action (LTC-803) regulations at Section 8.7206.18.

8.7557 Wraparound Services

8.7557.A Wraparound Services Eligibility

1. Wraparound Services are available as a covered benefit to Members enrolled in the HCBS Children's Habilitation Residential Program Waiver

8.7557.B Wraparound Services Description and Definition

1. Wraparound services align strategies, interventions, and supports for the Member and family, to prevent the need for out of home placement. This service may be utilized in maintaining stabilization, preventing Crisis situations, and/or de-escalation of a Crisis.

2. Wraparound services include Wraparound Plan and Prevention and Monitoring which are billed separately.

3. A Crisis may be self-identified, Family identified, and/or identified by an outside party.

4. Wraparound Service may be provided individually, or in conjunction with the Child and Youth Mentorship service, defined at 8.7512.

8.7557.C CHRP Wraparound Plan

1. The Wraparound Facilitator is responsible for the development of a Wraparound Plan with action steps to implement support strategies, prevent, and/or manage a future Crisis to include, but not limited to:

   a. The unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Member and family.

   b. Environmental modifications.

   c. Support needs in the Family home.

   d. Respite services.

   e. Strategies to prevent Crisis triggers.

   f. Strategies for Predictive and/or Increased Risk Factors.

   g. Learning new adaptive or life skills.

h. Behavioral or other therapeutic interventions to further stabilize the Member emotionally and behaviorally and to decrease the frequency and duration of any future behavioral Crisis.

i. Medication management and stabilization.

j. Physical health.

k. Identification of training needs and connection to training for Family Members, natural supports, and paid staff.

l. Determination of criteria to achieve stabilization in the Family home.

m. Identification of how the plan will be phased out once the Member has stabilized.

n. Contingency plan for out of home placement.

o. Wraparound Support Team may include Family caregivers, other Family Members, service providers, natural supports, professionals, and Case Managers required to implement the Wraparound Plan.

p. Dissemination of the Wraparound Plan to all individuals involved in plan implementation.

2. Revision of strategies shall be a continuous process by the Wraparound Support Team in collaboration with the Member, until the Member is stable and there is no longer a need for Wraparound Support Services.

3. On-going monitoring after completion of the Wraparound Plan may be provided if there is a need to support the Member and their Family in connecting to any additional resources needed to prevent a future Crisis.

8.7557.D Prevention and Monitoring

1. Follow-up services include monitoring to ensure that triggers to the Crisis have been addressed in order to maintain stabilization and prevent a future Crisis.

2. Monitoring of the Wraparound Plan shall occur at a frequency determined by the Member's needs and include at a minimum, visits to the Member's home, review of documentation, and coordination with other Professionals and/or Members of the Wraparound Support Team to determine progress.

3. Services include a review of the Member's stability and monitoring of Increased Risk Factors that could indicate a repeat Crisis.

4. Revision of the Wraparound Plan shall be completed as necessary to avert a Crisis or Crisis escalation.

5. Services include ensuring that follow-up appointments are made and kept.

8.7557.E Wraparound Services Provider Agency Requirements

1. Individuals providing Wraparound Services shall meet the following criteria:

    a. The Wraparound Plan Facilitator shall:

        i. Have a Bachelor's degree in a human behavioral science or related field of study; or

        ii. Have experience working with Long-Term Services and Supports (LTSS) populations, in a private or public social services Agency which may substitute for the required education on a year for year basis

            1) When using a combination of experience and education to qualify, the education shall have a strong emphasis in a human behavioral science field.

        iii. Have received Certification through a Nationally Accredited Wraparound Program.

            1) Training and Certification must encompass all of the following:

                a) Trauma informed care.

                b) Youth mental health first aid.

                c) Crisis support and planning.

                d) Positive Behavior Supports, behavior intervention, and de-escalation techniques.

                e) Cultural and linguistic competency.

                f) Family and youth servicing systems.

                g) Family engagement.

                h) Child and adolescent development.

                i) Accessing community resources and services.

                j) Conflict resolution.

                k) Intellectual and Developmental Disabilities.

l) Mental health topics and services.

m) Substance abuse topics and services.

n) Psychotropic medications.

o) Motivational interviewing.

p) Prevention, detection and reporting of mistreatment, abuse, neglect, and exploitation.

iv. Complete re-certification in wraparound training at least every other year or as dictated by wraparound training program.

8.7558 Workplace Assistance

8.7558.A Workplace Assistance Service Eligibility

1. Workplace Assistance is available to Members enrolled in one of the following HCBS waivers:

   a. Developmental Disabilities Waiver

   b. Supported Living Services Waiver

8.7558.B Workplace Assistance Service Definition

1. Workplace Assistance provides work-related supports for Members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver that is above and beyond what could be regularly supported by the workplace supervisor, co-workers, or job coach, in order to maintain an individual job in an integrated work setting for which the Member is compensated at or above minimum wage. Training/Job Coaching, accommodations, technology, and natural supports are to be used first to maximize the Member's independence and minimize the need for the consistent presence of a paid caregiver, through Workplace Assistance. As such, the degree to which the Member must be supported by a paid caregiver through the Workplace Assistance service, shall be based on the specific safety-related need(s) identified in the Person-Centered planning process for the Member at their worksite.

8.7558.C Workplace Assistance Service Inclusions

1. Workplace Assistance:

   a. Is provided on an individual basis, not within a group and cannot overlap with job coaching;

b. Occurs at the Member's place of employment, during the Member's work hours, and when needed may also be used:

i. Immediately before or after the Member's employment hours; or

ii. during work-related events at other locations.

c. Includes but is not limited to promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs, redirecting, reminding to follow work-related protocols/strategies, and ensuring other identified needs are met so the Member can be integrated and successful at work; and

d. May include activities beyond job-related tasks that support integration at work, such as assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events.

2. Workplace Assistance is appropriate for and available to:

a. Members who require Intensive Supervision or have a documented need which warrants a Rights Modification requiring extensive supervision, such as, a court order or the Member meeting Public Safety Risk or Extreme Risk-to-Self criteria.

b. Members whose support team agrees there is justification for a paid caregiver to be present for a portion of the hours worked due to safety concerns; and those needs are beyond what could be addressed through natural supports, technology, or intermittent Job Coaching. The specific safety concerns identified by Members and their support teams may include, but are not limited to:

i. Regularly demonstrating behaviors that cause direct harm to themselves or others; or

ii. Intentionally or unintentionally putting themselves in unsafe situations frequently; or

iii. Often demonstrating poor safety awareness or making poor decisions related to personal safety.

8.7558.D Workplace Assistance Service Access and Authorizations

1. Prior to Workplace Assistance being authorized, including at the Person-Centered Support Plan's annual renewal, the Member and their support team shall determine that alternatives to paid caregiver supports were fully explored, by considering the factors listed below. Documentation of these considerations shall be reflected in the Member's Case Management record.

a. Job Coaching services have been or will be leveraged to promote the Member's independence and minimize the need for the presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, promoting natural supports, integrating technology, and using systematic instruction techniques.

b. The specific safety concern(s) to be addressed and how the Workplace Assistance staff could support the Member in addressing the safety concerns while facilitating integration and independence at work.

c. The nature of the job and work location, the Member's longevity with the employer, the degree of continuity at the Member's place of employment, and the likelihood of the Member putting themselves/others in harm's way, despite training, technology, and cues from natural supports.

d. The Member's desire to have a paid caregiver present for the identified time periods.

e. The Supported Employment provider's informed opinion regarding the need for paid caregiver support beyond intermittent Job Coaching. This opinion shall be grounded in Employment First concepts as evidenced by:

i. The provider's completion of a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment Certification (Certification); or

ii. If the Supported Employment provider does not possess this credentialing, then the Supported Employment provider or the Case Manager may consult with:

1) By someone who does possess either a Training Certificate or Certification

2) Or a representative from the Department who oversees the Workplace Assistance benefit.

8.7558.E Workplace Assistance Service Exclusions and Limitations

1. A Member's supervision level is not the sole factor which justifies the need for this service, therefore, the supervision level shall not be elevated in order to access the service. The Member's supervision level at the worksite shall be based on actual need related to the Member at work.

2. A total number of 7,112 units per support plan year shall be available for Workplace Assistance services in combination with other Supported Employment and day habilitation services. One unit equals 15 minutes of service.

8.7558.F Workplace Assistance Service Provider Agency Requirements

1. Workplace Assistance staff shall consistently seek to promote the Member's independence and integration at work. Where possible, efforts shall be made to reduce or eliminate the need for Workplace Assistance services over time, and the efforts and progress shall be documented by the provider.

2. The training for Workplace Assistance staff shall:

    a. Include fundamentals of Employment First principles with emphasis on promoting independence and inclusion; and

    b. Provide insight regarding a paid caregiver's role at a Member's place of employment such that the Workplace Assistance staff's presence does not hinder the Member's interaction with co-workers, customers, and other community Members.

8.7559 Youth Day Service

8.7559.A Youth Day Services Eligibility

1. Youth Day Service is a covered benefit available to Members enrolled in the HCBS Children's Extensive Support Waiver.

8.7559.B Youth Day Services Definition

1. Youth Day Service is the care and supervision of Members ages 12 through 17 while the primary caregiver works, volunteers, or seeks employment.

8.7559.C Youth Day Services Inclusions

1. Youth Day Service may be provided in the residence of the Member, the Youth Day Service Provide Agency, or in the community.

2. Youth Day Service shall be provided according to an individual or group rate as defined below:

    a. Individual: the Member receives Youth Day Services with a staff ratio of 1:1, billed at 15-minute unit. There are no other youth in the setting also receiving Youth Day Service, Respite or third-party supervision.

    b. Group: the Member receives supervision in a group setting with other individuals who may or may not have a disability. Reimbursement is limited to the Member.

8.7559.D Youth Day Services Exclusions and Limitations

1. This service is limited to Members ages 12 through 17.

2. This service may not substitute for or supplant special education and related services included in a Member's Individualized Education Plan (IEP) developed

under Part B of the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 (2011). This includes after school care provided through any education system and funded through any education system for any student.

3. This service may not be used to cover any portion of the cost of camp.

4. This service is limited to 10 hours per calendar day and 90 days per certification period The Department may approve a higher amount based on a need due to the Member's disability or unique family circumstances.

8.7560 State Funded Supported Living Services (State-SLS) Program

1. The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide services to individuals with an intellectual or Developmental Disability to remain in their community. The State-SLS program shall not supplant Home and Community-Based Services for those who are currently eligible.

8.7560.A State-SLS Definitions

1. Corrective Action Plan means a written plan, which includes the detailed description of actions to be taken to correct non-compliance with State-SLS requirements, regulations, and direction from the Department, and includes the date by which each action shall be completed and the individuals responsible for implementing the action.

2. Community Resource means services and supports that a Member may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to, services provided through private insurance, non-profit services and other government programs.

3. Natural Supports means an informal relationship that provides assistance and occurs in the Member's everyday life including, but not limited to, community supports and relationships with Family Members, friends, co-workers, neighbors and acquaintances

4. Performance and Quality Review means a review conducted by the Department or its Contractor at any time to include a review of required Case Management services performed by the Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements

5. State Fiscal Year means a 12-month period beginning on July 1 of each year and ending June 30 of the following calendar year.

8.7560.B State-SLS Administration

1. The Case Management Agency (CMA) shall administer the State Supported Living Services (State-SLS) program according to all applicable statutory, regulatory and contractual requirements, and Department policies and guidelines.

    a. The Case Management Agency is responsible for providing Case Management to all individuals enrolled in the State-SLS program.

    b. The Case Management Agency shall have written procedures related to the administration, Case Management, service provision, and waiting list for the State-SLS program.

    c. All records must be maintained in accordance with Section 8.7405.

    d. The Case Management Agency shall maintain a waiting list of eligible individuals for whom Department funding is unavailable in accordance with Section 8.7560.G.

    e. The Case Management Agency shall develop procedures for determining how and which individuals on the waiting list will be enrolled into the State-SLS program that comply with all applicable statutory, regulatory and contractual requirements including Section 8.7560.G.

    f. Any decision to modify, reduce or deny services or supports set forth in the State-SLS program, without the Individual's or Legally Authorized Representative's agreement, are subject to the requirements in Section 8.7202.S.

2. Member Eligibility

    a. General Eligibility requirements

        i. Individuals must be a resident of Colorado;

        ii. Be eighteen (18) years of age or older; and

        iii. Be determined to have an intellectual or Developmental Disability pursuant to the procedures set forth in Section 8.7202.D.

    b. Eligibility for the State-SLS program does not guarantee the availability of services under this program.

3. General Provisions

    a. The availability of services offered through the State-SLS program may not be consistent throughout the State of Colorado or between Case Management Agencies.

b. An individual enrolled in the State-SLS program shall access all benefits available under the Medicaid State Plan, HCBS Waiver or EPSDT, if available, prior to accessing services under the State-SLS program. Services through the State-SLS program may not duplicate services provided through the State Plan when available to the Member.

c. Evidence of attempts to utilize all other public benefits and available and accessible community resources must be documented in the State-SLS individualized Support Plan by the Case Manager, prior to accessing State-SLS services or funds.

d. The State-SLS program shall be subject to annual appropriations by the Colorado General Assembly.

e. These regulations shall not be construed to prohibit or limit services and supports available to persons with Intellectual and Developmental Disabilities that are authorized by other state or federal laws.

f. When an individual is enrolled only in the State-SLS program the Case Manager shall authorize a Provider Agency to deliver the services, when available.

g. The Case Manager may authorize services from multiple State-SLS service categories at once, unless otherwise stated.

h. Unless otherwise specified, State-SLS services may be utilized in combination with other community resources and/or Medicaid services. State-SLS services shall not be duplicative of other resources or HCBS services, and all other available and accessible resources shall be utilized before State-SLS services.

4. Performance and Quality Review

a. The Department shall conduct a Performance and Quality Review of the State-SLS program to ensure that the Case Management Agency is in compliance with all statutory and regulatory requirements.

b. A Case Management Agency found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within 10 business days of the date of the written request from the Department. A Corrective Action Plan shall include, but is not limited to:

i. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;

ii. A detailed timeframe for completing the actions to be taken;

iii. The employee(s) responsible for implementing the actions; and

iv. The estimated date of completion.

c. The Case Management Agency shall notify the Department in writing, within 3 business days if it will not be able to present the Corrective Action Plan by the due date. The Case Management Agency shall explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.

i. Upon receipt of the proposed Corrective Action Plan, the Department will notify the Case Management Agency in writing whether the Corrective Action Plan has been accepted, modified, or rejected.

ii. In the event that the Corrective Action Plan is rejected, the Case Management Agency shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

iii. The Case Management Agency shall begin implementing the Corrective Action Plan upon acceptance by the Department.

iv. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.7560.C State-SLS Inclusions and Covered Services

1. Services for individuals waiting for HCBS waiver enrollment.

a. Eligible Members may receive the following services:

i. All HCBS Waiver Services identified as available to Members enrolled in the SLS waiver as identified throughout section 8.7500 et seq.

ii. Service limitations in the HCBS SLS waiver and set forth in section 8.7500 et seq. apply to the State-SLS program.

iii. When a Provider Agency is not available to provide services, the Case Management Agency may authorize the services identified in the State-SLS Individual Support Plan.

2. Services for Individuals Experiencing Emergency Situations or Temporary Hardships

a. State-SLS may be utilized to provide the following emergency or temporary services to individuals who have been determined to meet the criteria for an Intellectual / Developmental Disability as specified in Section 8.7202.D, in situations where temporary assistance can alleviate the need for a higher Level of Care. These services cannot be duplicative and shall not be accessed if available through other sources. In order to access State-SLS, an Individual Support Plan must be completed.

i. Payment of utilities:

1) Paying gas/electric bills and/or water/sewer bills:

a) Documentation must be maintained by the Case Management Agency that all alternative programs, community support, and natural supports were utilized before any State-SLS funds were authorized.

ii. Services with acquiring emergency food, at a retail grocery store when there are no other community resources available

1) Documentation must be maintained by the Case Management Agency demonstrating the reason why State-SLS funds were utilized over other sources of emergency food. This may include but is not limited to:

a) Other emergency food programs are not available.

b) Home delivered meals have unexpectedly stopped.

iii. Pest infestation abatement:

1) Documentation must be maintained by the Case Manager showing that infestation abatement is not covered under the Member's residential agreement or lease.

2) Documentation that the pest abatement professional is licensed in the state of Colorado, must be maintained by the Case Management Agency and provided to the Department upon request.

3) Pest infestation abatement shall not be authorized if the Member resides in a provider owned and/or controlled property.

4) Documentation showing proof of payment must be maintained by the Case Management Agency administering the State-SLS program.

b. Service Limitations

i. Support for utilities shall not exceed $1,000.00 in a State Fiscal Year.

ii. Support for pest infestation abatement shall not exceed $2,000.00 in a State Fiscal Year.

1) Supports for pest infestation abatement shall not cover more than one infestation event in a State Fiscal Year; and

2) Multiple treatments per event may be authorized, if determined necessary by a licensed pest abatement professional.

iii. Emergency food support shall not exceed $400.00 in a State Fiscal Year.

3. Services to Support Independence in the Community.

a. State-SLS may be utilized to provide an individual found eligible for or enrolled in an HCBS Medicaid waiver, with a one-time payment or acquisition of needed household items, in the event the Member is moving into a residence as defined in Section 8.7101.I.2.e..

i. State-SLS funds may be utilized for payment or acquisition of:

1) Initial housing costs including but not limited to a one-time initial set up for pantry items and/or kitchen supplies and/or furniture purchase.

ii. Individuals enrolled in the HCBS-DD waiver residing in a Group Residential Services and Supports (GRSS) or Individual Residential Services and Supports - Host Home (IRSS-HH) setting are not eligible for this Support.

b. State-SLS funds may support someone to have greater independence when they are moving into their own home, by paying for housing application fees.

c. The Case Management Agency shall maintain receipts or paid invoices for purchases authorized in this section. Receipts or paid invoices must contain at a minimum, the following information: business name, item(s) purchased, item(s) cost, date paid, and description of items purchased. Documentation must be made available to the Department upon request. All items must be purchased from an established retailer that has a valid business license.

d. Service limitations

i. The one-time furniture purchase shall not exceed $300.00.

ii. The one-time initial pantry set up shall not exceed $100.00.

iii. The one-time purchase of kitchen supplies shall not exceed $200.00.

iv. The payment of housing application fees are limited to five (5) in a State Fiscal Year.

4. On-going State-SLS Support.

a. State-SLS funds may be authorized by the Case Management Agency for individuals who have been determined to meet the DD Determination requirements, but do not meet the requirements to be enrolled in HCBS-SLS Waiver Section 8.7101.I.

i. All HCBS Waiver Services identified as available to Members enrolled in the SLS waiver as identified throughout Section 8.7500, et seq.

ii. Service limitations and service rules found in the HCBS-SLS eligible Waiver Services in Section 8.7500, et seq. apply to the State-SLS program.

iii. A Provider Agency is authorized to provide State-SLS services; and

b. When an individual is enrolled in an HCBS waiver, State-SLS services may be utilized in combination with other community resources and/or Medicaid services. State-SLS services shall not be duplicative of other resources or HCBS services, and all other available and accessible resources shall be utilized before State-SLS services.

i. Individuals enrolled in HCBS SLS and HCBS DD shall not use State SLS for ongoing services but may use State SLS for emergency services or temporary hardships only.

ii. Only a Provider Agency can provide these services.

c. Service Limitation

i. Total authorization limit for the plan year shall be determined by the Department and be communicated annually on the State-SLS Program rate schedule.

8.7560.D State-SLS Individual Support Plan

1. State-SLS Members are required to have a State SLS Individual Support Plan that is signed and authorized by the CMA Case Manager and the Member, or their Legally Authorized Representative.

2. The State-SLS Individual Support Plan shall be developed through an in-person face to face meeting that includes at least, the individual seeking services and the Case Manager. Upon Department approval, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or Member (e.g. natural disaster, pandemic, etc.

3. If a Member seeks additional services or identifies a change in need, the State-SLS Individual Support Plan shall be reviewed and updated by the Case Manager prior to any change in authorized services.

4. The State-SLS Individual Support Plan shall be effective for no more than one year and reviewed at least every 6 months, in a face-to-face meeting with the Member or on a more frequent basis if a change in need occurs. Upon Department approval, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or Member (e.g. natural disaster, pandemic, etc.)

    a. Any changes to the provision of the services identified in the State-SLS Individual Support Plan are subject to available funds within the defined service area.

    b. Any decision to modify, reduce or deny services set forth in the State-SLS Individual Support Plan, without the Member's consent is subject to the Dispute Resolution Process found in Section 8.7202.S.

5. The State-SLS Individual Support Plan and all supporting documentation will be maintained by the Case Manager and will be made available to the Department upon request.

6. The State-SLS Individual Support Plan shall include the following:

    a. The services authorized, the Member's identified needs and how the services will address the needs.

    b. The scope, frequency, duration, and cost of each service.

    c. Other community resources being utilized.

d. Documentation demonstrating why the individual enrolled in State-SLS is not eligible or enrolled in a HCBS Medicaid waiver or documentation showing which HCBS waiver the individual is enrolled in;

e. Documentation demonstrating if other public or community resources have been utilized and why State-SLS funds are being utilized instead of or in combination with other resources.

f. Total cost of the services being authorized.

g. Information to support authorization of services for Individuals Experiencing Temporary Hardships, including:

i. A description of the hardship.

ii. The reason for the hardship.

iii. The length of time the support will be authorized, including the date of the onset of the hardship and the date it is expected to end.

iv. Total amount needed to support the individual and what other community resources are contributing.

v. A plan to reasonably ensure the hardship is temporary.

vi. A plan to reasonably ensure that dependence on State-SLS funds will be temporary.

vii. The dates of when the long-term solution will be in place and when the temporary hardship is expected to end.

viii. Documentation demonstrating how utilizing State-SLS funds will lead to the Member gaining more independence in the community or maintaining their independence in the community

8.7560.E State-SLS Case Management Services

1. Administration

a. The Case Management Agency shall comply with all requirements set forth in Section 8.7200, et seq.

2. Case Management Duties:

a. The Case Manager shall coordinate, authorize, and monitor services based on the approved State-SLS Individual Support Plan.

i. The Case Manager shall have, based on the Member's preference, a face to face or telephone contact once per quarter with the Member.

b. The Case Manager shall assist Members to gain access to other resources for which they are eligible and to ensure Members secure long-term support as efficiently as possible.

c. The Case Manager shall provide all State-SLS documentation upon the request from the Department.

d. Referrals to the State-SLS program shall be made through the Case Management Agency in the geographic defined service area the Member or Applicant resides in.

8.7560.F State-SLS Transferring Services Between Case Management Agencies

1. When an individual enrolled in, or on the waiting list for, the State-SLS program moves to another Case Management Agency's defined service area, and wishes to transfer their State-SLS, the following procedure shall be followed:

   a. The originating Case Management Agency will contact the receiving Case Management Agency to inform them of the individual's desire to transfer.

   b. The originating Case Management Agency will send the State-SLS Individual Support Plan to the receiving Case Management Agency, where the receiving Case Management Agency will determine if appropriate State-SLS funding is available or if the individual will need to be placed on a waiting list. The receiving Case Management Agency's decision of service availability will be communicated in the following way:

      i. The receiving Case Management Agency will notify the individual seeking transfer of its decision by the individual's preferred method, no later than 10 business days from the date of the request; and

      ii. The receiving Case Management Agency will notify the originating Case Management Agency of its decision by U.S. Mail, phone call or email of its decision no later than 10 business days from the date of the request.

   c. The decision shall clearly state the outcome of the decision including:

      i. The basis of the decision; and

      ii. The contact information of the assigned Case Manager or waiting list manager.

d. The originating Case Management Agency shall contact the individual requesting the transfer no more than five days from the date the decision was received to:

i. Ensure the individual understands the decision; and

ii. Support the individual in making a final decision about the transfer.

e. If the transfer is approved, there shall be a transfer meeting in-person when possible, or by phone if geographic location or time does not permit, within 15 business days of when the notification of service determination is sent out by the receiving Case Management Agency. The transfer meeting must include but is not limited to the transferring individual and the receiving Case Manager. Any additional attendees must be approved by the transferring individual.

f. The receiving Case Management Agency must ensure that:

i. the transferring individual meets their primary contact of the receiving Case Management Agency.

ii. The individual is informed of the date when services will be transferred, when services will be available, and the length of time the services will be available.

g. The receiving Case Manager shall have an in-person face to face meeting with the Member to review and update the State-SLS Individual Support Plan, prior to the services being authorized. Upon Department approval, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or Member (e.g. natural disaster, pandemic, etc.).

8.7560.G State-SLS Waiting List Protocol

1. Persons determined eligible to receive services under the State SLS program, shall be eligible for placement on a waiting list for services when state funding is unavailable.

2. Waiting lists for persons eligible for the State SLS program shall be administered by the Case Management Agency, uniformly administered throughout the State and in accordance with these rules and the Department’s procedures.

3. Persons determined eligible shall be placed on the waiting list for services in the Case Management Agency service area of residency.

a. The date used to establish a person's placement on a waiting list shall be:

i. The date on which an individual is determined eligible for the State-SLS program through the DD Determination and the identification of need.

4. As funding becomes available in the State SLS program in a defined service area, persons shall be considered for services in order of placement on the local Case Management Agency's waiting list.

5. Individuals with no other State or Medicaid funded services or supports will be given priority for enrollment including individuals who lose Medicaid eligibility and lose Medicaid Waiver Services.

6. Exceptions to these requirements shall be limited to:

a. Emergency situations or temporary hardships where the health, safety, and welfare of the person or others is greatly endangered, and the emergency cannot be resolved in another way. Emergencies are defined as follows:

i. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; whose primary residence during the night is a public or private facility that provides temporary living accommodations; any other unstable or non-permanent situation; is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

ii. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in their present living situation and his/her health, safety or well-being are in serious jeopardy.

iii. Danger to Others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by them. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

iv. Danger to Self: a person's medical, psychiatric, or behavioral challenges are such that they are seriously injuring/harming themself or is an imminent danger of doing so.

v. Loss or Incapacitation of Primary Caregiver: a person's primary caregiver is no longer in the person's primary residence to provide care; the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; the primary caregiver is age 65 years or older and continuing to provide care poses an imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a

professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.

7. Documentation demonstrating how the individual meets the emergency criteria shall be kept on file at the Case Management Agency and made available to the Department upon request.

8.7560.H State-SLS Case Management Agency and Provider Agency Reimbursement

1. A Provider Agency must submit all claims, payment requests, and/or invoices to the Case Management Agency for payment within thirty (30) days of the date of service, except for Services and Supports rendered in June, the last month of the State Fiscal Year. All claims, payment requests, and/or invoices for services rendered in June must be submitted by the date specified by the Case Management Agency to ensure payment.

2. Case Management Agency must submit all claims, payment requests, and/or invoices in the format and timeframe established by the Department.

3. Case Management Agency and Provider Agency claims, payment requests, or invoices for reimbursement shall be made only when the following conditions are met:

   a. Services are provided by a qualified Provider Agency.

   b. Services are authorized and delivered in accordance with the frequency, amount, scope and duration of the service as identified in the Member's State-SLS Individual Support Plan;

   c. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the State-SLS Individual Support Plan and in accordance with the service definition;

   d. All Case Management Activities must be documented and maintained by the Case Management Agency.

4. Case Management Agency and Provider Agencies shall maintain records in accordance with Sections 8.130.2 and 8.7405.

5. Case Management Agency and Provider Agency reimbursement shall be subject to review by the Department and may be completed after the payment has been made to the Case Management Agency and Provider Agency.

6. Case Management Agencies and Provider Agencies are subject to all program integrity requirements in accordance with Section 8.076.

7. The reimbursement for this service shall be established in the Department's published fee schedule.

8. Except where otherwise noted, Provider Agency reimbursement shall be based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private provider agencies and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin and can be accessed through the Department's fiscal agent's website.

    a. State-SLS rates shall be set and published in the provider bulletin annually each State Fiscal Year.

8.7561 Family Support Services Program (FSSP)

8.7561.A FSSP Administration

1. The Case Management Agency (CMA) shall administer the Family Support Services Program (FSSP), subject to available appropriations and according to the rules, regulations, policies and guidelines of the Department, local Family Support Council (FSC) and Case Management Agency.

2. The Case Management Agency shall ensure that the FSSP is implemented within its defined service area.

3. The Case Management Agency shall designate one (1) person as the contact for the overall implementation and coordination of the FSSP.

4. Referrals to the FSSP shall be made through the Case Management Agency pursuant to Section 8.7202.B.

5. Nothing in these rules and regulations shall be construed as to prohibit or limit services and supports available to a Member with an Intellectual and Developmental Disability or Developmental Delay and their families which are authorized by other state or federal laws.

6. The Case Management Agency, in cooperation with the local FSC, shall ensure that the FSSP is publicized within the designated service area.

7. The Case Management Agency shall develop written policies and procedures for the implementation and ongoing operation of the FSSP, which must be kept on file and made available to the Department or the public, upon request.

8.7561.B FSSP Family Support Council (FSC)

1. The Case Management Agency shall assist its defined service area to establish and maintain an FSC pursuant to Section 25.5-10-304, C.R.S.

2. The Case Management Agency shall establish an FSC roster that includes the names of Members, type of membership and identifies the chairperson. The roster shall be available to the Department or the public, upon request.

3. Composition of the FSC:

   a. The majority of the members and the chairperson of each FSC shall be Family Members of an individual with an Intellectual and Developmental Disabilities or Developmental Delay.

   b. New members of the FSC shall be recruited from the service area. New members shall be approved by the current FSC and the governing body of the Case Management Agency.

   c. The members of the FSC shall receive written notice of their appointment.

   d. The Case Management Agency shall ensure an orientation and necessary training regarding the duties and responsibilities of the FSC is available for all council members. The training and orientation shall be documented with a record of the date of the training, who provided the training, training topic, and names of attendees.

   e. The size of the FSC shall be sufficient to meet the intent and functions of the council, but no fewer than five (5) persons, unless approved by the Department.

   f. Each FSC shall establish the criteria for tenure of members, selection of new members, the structure of the council and, in conjunction with the Case Management Agency, a process for addressing disputes or disagreements between the FSC and the Case Management Agency. Such processes shall be documented in writing. Processes may include a request for mediation assistance from the Department.

4. The FSC duties include providing guidance and assistance to the Case Management Agency on the following:

   a. Overall implementation of the FSSP;

   b. Development of the written annual FSSP report for the defined service area, as defined at Section 8.7561.K;

   c. Development of written procedures describing how families are prioritized for FSSP funding;

   d. Development of written policy defining how an emergency fund is established, funded and implemented. The policy must include a definition of a short-term Crisis or emergency and the maximum amount of funds a Family may receive per event and/or year;

e. Provide recommendations on defining the “other” service category within the parameters as defined in this part;

f. Monitor the implementation of the overall services provided in the defined service area; and

g. Provide recommendations on how to assist families who are transitioning out of the FSSP.

8.7561.C FSSP Member Eligibility

1. Any individual with an Intellectual and Developmental Disability or Developmental Delay, as determined pursuant to Section 25.5-10-211, C.R.S., living with their Family is eligible for the FSSP. Living with a Family means that the individual's place of residence is with that family.

   a. If an individual does not reside in the primary residence because of transition into or out of the home for more than 6 months, that individual is no longer eligible for FSSP.

   b. The Case Management Agency, in cooperation with the local FSC, shall determine what constitutes a transition.

2. The Family and eligible individual shall reside in the State of Colorado.

3. Eligibility for the FSSP does not guarantee the availability of services under this program.

8.7561.D FSSP Direct Services and Inclusions

1. Services and supports available under the FSSP may be purchased from any provider that is able to meet the individual needs of the family.

2. All services must be needed as a result of the individual’s Intellectual and Developmental Disability or Developmental Delay and shall not be approved if the need is a typical age-related need. Correlation between the need and the disability must be documented in the Family Support Plan (FSP).

3. All services must be provided in the most cost-effective manner, meaning the least expensive manner to meet the need.

4. All services shall be authorized pursuant to the FSP.

5. Services provided to the Family through the FSSP shall not supplant third party funding sources available to the Family including, but not limited to, public funding, insurance, or trust funds.

6. Case Management Agencies shall not charge a separate fee for assisting individuals to access services identified on the FSP.

7. FSSP funds shall not be used for any donation to religious, political, or otherwise causes, or activities prohibited by law.

8. Included Direct Services:

    a. Assistive technology is equipment or upgrades to equipment, which are necessary for the individual with an Intellectual and Developmental Disability or Developmental Delay to communicate through expressive and receptive communication, move through or manipulate his or her environment, control his or her environment, or remain safe in the family home. Assistive technology includes non-Adaptive Equipment that meets disability-specific needs identified in the Family Support Plan.

    b. Environmental engineering is a home or vehicle modification needed due to the individual's disability and is not a regular maintenance or modification needed by all owners. Modifications to the home or vehicle must be:

        i. Necessary due to the individual's Intellectual and Developmental Disability or Developmental Delay;

        ii. Needed due to health and safety; or

        iii. To allow the individual to attain more independence;

        iv. Modifications must be completed in a cost-effective manner. Cost-effective manner means the least expensive manner to meet the identified need. Home modifications are to be limited to the common areas of the home the individual with an Intellectual and Developmental Disability frequents, the individual's bedroom, and one bathroom. Other bedrooms and bathrooms shall not be modified. All devices and adaptations must be provided in accordance with applicable state or local building codes and/or applicable standards of manufacturing, design, and installation. Only homes or vehicles occupied and owned by the Family where the eligible individual resides may be modified. Minor modifications may be made to rental units with the permission of the landlord. Rental modifications must be made in a way that the modification can be moved with the eligible individual during a change in residence.

    c. Medical and dental items prescribed by a medical professional licensed and qualified to prescribe such items and are needed to maintain or attain physical health. Medical, dental, and vision services, exams and procedures are available when not covered by another source.

i. Over the counter medications and vitamins are excluded, except as indicated at Section 8.800.4.D, when prescribed by a medical professional licensed and qualified to write such prescriptions.

d. Other: Services in this category must be identified in the FSP, are specific to the family, and are limited to:

i. A consultant and/or advocate to assist a Family with accessing services outside of the Case Management Agency.

ii. Recreational needs of the individual with an Intellectual and Developmental Disability or Developmental Delay when the need of recreation is above and beyond the typical need due to the disability or delay. The cost of family recreation passes shall the cost of one family pass per fiscal year and shall be limited to use only at community recreation centers, except in communities where community recreation centers do not exist and in cases where the use of an alternative recreation facility is justified by a need related to the disability or delay, and the activity and/or facility is recommended by a licensed or certified professional qualified to make the recommendation. In such circumstances, the Case Management Agencies shall document the professional recommendation and demonstrate that the chosen facility is the least expensive option to meet the family's needs.

1) The following items are specifically excluded under the FSSP and shall not be eligible for coverage:

a) Entrance fees for:

i) Zoos;

ii) Museums;

iii) Movie theaters, performance theaters, concerts, other entertainment venues; and

iv) Professional and minor league sporting events.

b) Outdoors play structures; and

c) Batteries for recreational items.

iii. Specialized services as identified by the FSC and Case Management Agency included in their written policy and are available to any Family receiving ongoing FSSP assistance in the service area.

e. Parent and sibling support, which may include special resource materials or publications, cost of care for siblings, or behavioral services or counseling.

f. Professional services are services which require licensure or certification to treat a human condition other than medical, dental or vision, and is provided to the individual with an Intellectual and Developmental Disability or Developmental Delay. Professional services must be provided by qualified, certified and/or licensed personnel in accordance with the standards and practices of the industry. Professional services may include related support items, equipment, or activities which are recommended as part of the therapy with supporting documentation from the treating professional. Insurance expenses directly incurred by the individual with an Intellectual and Developmental Disability or Developmental Delay are included.

g. Program expenses are services provided by the Case Management Agency for the benefit of multiple families; and are funded through the direct service line. Program expenses include:

i. Maintenance, operation, or enhancement of a resource library that consists of an inventory of goods and equipment used to meet the needs of individuals with an Intellectual and Developmental Disability or Developmental Delay on a temporary basis;

ii. Costs associated with participation with other community agencies in the development, maintenance, and operation of projects, supports or services that benefit individuals with an Intellectual and Developmental Disability or Developmental Delay;

ii. Development or coordination of a training event for families;

iv. Costs of an event sponsored by the Case Management Agency for all eligible individuals and their families to meet other families to provide socialization and an opportunity to build a network of support; or

v. Development and coordination of group respite.

vi. The FSC in conjunction with the Case Management Agency shall determine the maximum amount of direct services to be used for program expenses.

h. Respite is the temporary care of an individual with an Intellectual and Developmental Disability that provides relief to the primary caregiver.

i. Transportation is the direct cost to the Family that is higher than costs typically incurred by other families because of specialty medical

appointments or therapies. Specialty medical appointments or therapies are defined as appointments needed due to the individual's Intellectual and Developmental Disability or Developmental Delay. The direct cost is the cost of transportation, lodging, food expense, and long-distance telephone calls to arrange for or coordinate medical services which are not covered by other sources.

8.7561.E FSSP Waiting List

1. The Case Management Agency shall maintain an accurate and up-to-date waiting list of eligible individuals for whom FSSP funding is unavailable in the current fiscal year.

2. In cooperation with the local FSC, the Case Management Agency shall develop written procedures for determining how and which individuals on the waiting list will be enrolled into the FSSP.

3. Individuals receiving ongoing FSSP funding shall not be listed on the waiting list for the program.

4. Individuals determined to be prioritized for FSSP funding shall be served prior to individuals determined at a lower level of prioritization.

5. The Case Management Agency must inform eligible families of the program and waiting list procedures and offer Assessment and enrollment onto either the waiting list or the program, based on the Assessment and available appropriations.

6. Any individual on the waiting list for FSSP may receive emergency funding through the Case Management Agency through the FSSP, if the needs meet the parameters set by the FSC and the Case Management Agency.

7. Waiting lists shall not exist for any Case Management Agency that does not expend all FSSP direct service funds.

8.7561.F FSSP Prioritization for Family Support Services (FSSP) Funding

1. Case Management Agencies must ensure that families with the highest assessed needs shall be prioritized for FSSP state funding.

2. Case Management Agencies, in conjunction with the FSC, will develop written procedures that describe how families shall be prioritized and notified of the prioritization process.

3. The Assessment process shall be applied equally and consistently to all families who are assessed.

4. Case Management Agencies must distribute the prioritization process to families in their defined service area at the time the Family requests FSSP funding, when the individual is placed on the waiting list, or upon request.

5. The Case Management Agency must notify families in writing of the results of the Assessment.

6. All families, both on the waiting list and receiving FSSP services, shall be assessed for level of need on an annual basis or earlier if the family's circumstances change.

7. The Assessment must contain the following components:

    a. The qualifying individual's disability and overall care need, which includes:

        i. The type of disability or condition and the need and complexity of medical or personal care for the individual;

        ii. The need for, frequency of, and amount of direct assistance required to care for the individual; and

        iii. The types of services needed that are above and beyond what is typically needed for any individual.

    b. The qualifying individual's behavioral concerns, including how behaviors disrupt or impact the family's daily life, the level of supervision required to keep the individual and others safe, and the services and frequency required to help with the behaviors.

    c. The Family composition, which considers obligations and limitations of the Parent(s), the number of siblings, disabilities of other family members living in the home, and the level of stability of the family, such as pending divorce or age and disability of Parents.

    d. The family's access to support networks, which includes the level of isolation or lack of support networks for the family, such as not having extended family nearby, living in rural areas or availability of providers.

    e. The family's access to resources such as family income, insurance coverage, HCBS waivers, and/or other private or public benefits.

8.7561.G FSSP Case Management Responsibilities

1. Case management is the coordination of services provided for individuals with an Intellectual and Developmental Disability (IDD) or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education,

and other services to ensure non-duplication of services, and monitor the effective and efficient provision of services across multiple funding sources.

2. At minimum, the Case Manager is responsible for:

   a. Determining initial and ongoing eligibility for the FSSP;

   b. Development, application assistance, and annual re-evaluation of the Family Support Plan (FSP); and

   c. Ensuring service delivery in accordance with the FSP.

3. Family Support Plan Requirements

   a. Families enrolled into the FSSP shall have an individualized FSP which meets the requirements of an Individualized Plan, as defined in Sections 25.5-10-202 and 25.5-10-211, C.R.S., and includes the following information:

      i. The name of the eligible individual;

      ii. The names of Family Members living in the household;

      iii. The date the FSP was developed or revised;

      iv. The prioritized needs requiring support as identified by the family;

      v. The specific type of service or support, how it relates to the Family need and the individual's disability or Developmental Delay, and period which is being committed to in the FSP, including, when applicable, the maximum amount of funds which can be spent for each service or support without amending the FSP;

      vi. Documentation regarding cost-effectiveness of a service or support, which can include quotes, bids, or product comparisons but must include the reason for selecting a less cost-effective service or support, when applicable;

      vii. A description of the desired results, including who is responsible for completion;

      viii. The projected timelines for obtaining the service or support and, as appropriate, the frequency;

      ix. A statement of agreement with the plan;

      x. Signatures, which may include digital signatures of a family representative and an authorized Case Management Agency representative;

xi. The level of need;

xii. The length of time the funds are available; and

xiii. A description of how payment for the services or supports will be made.

b. The FSP shall integrate with other service plans affecting the Family and avoid, where possible, any unnecessary duplication of services and supports.

c. The FSP shall be reviewed at least annually or on a more frequent basis if the plan is no longer reflective of the family's needs.

i. Any changes to the provision of services and supports identified in the FSP are subject to available funds within the defined service area.

ii. Any decision to modify, reduce or deny services or supports set forth in the FSP, without the family's agreement, are subject to the requirements in Section 8.7201.D.

4. Emergency Fund

a. Each Case Management Agency shall establish an emergency fund that may be accessed by any individual eligible for the FSSP when needed due to an unexpected event that has a significant impact on the individual or family’s health or safety and impacts the family’s daily activities.

b. Any individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay determined by the Case Management Agency and living with Family shall be eligible to receive emergency funds regardless of the enrollment status of the family.

c. The Case Management Agency in conjunction with the Family Support Council shall develop written policies and procedures regarding the Emergency Fund. At a minimum the policies and procedures must:

i. Define the purpose of the emergency fund;

ii. Define an unexpected event and significant impact;

iii. Describe the process for accessing emergency funds;

iv. Describe how funding determinations are made;

v. Give a timeline of the determination of the request;

vi. Define the maximum funding amount per Family or per event; and

vii. Describe how families will be notified of the decision in writing.

8.7561.H FSSP Billing and Payment Procedures

1. The Case Management Agency shall develop and implement policies, procedures, and practices for maintaining documentation for the FSSP and reporting information in the format and timeframe established by the Department.

2. Families shall maintain and provide either receipts or invoices to the Case Management Agency documenting how funds provided to the Family through the FSSP were expended. The Case Management Agency shall maintain supporting documentation capable of substantiating all expenditures and reimbursements made to providers and/or families, which shall be made available to the Department upon request.

    a. When the Case Management Agency purchases services or items directly for families, the Case Management Agency shall maintain receipts or invoices from the service provider and documentation demonstrating that the provider was paid by the Case Management Agency. Receipts or invoices must contain, at a minimum, Member and/or Family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount due or paid.

    b. When the Case Management Agency reimburses families for services or items, the Case Management Agency shall ensure the Family provides the Case Management Agency with receipts or invoices prior to reimbursement. The Case Management Agency shall maintain receipts or invoices from the families, and documentation demonstrating that the Family was reimbursed by the Case Management Agency. The Case Management Agency must ensure all receipts or invoices provided by the families contain, at a minimum, Member and/or Family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

    c. When the Case Management Agency provides funding to the families for the purchase of services or items in advance, the Case Management Agency shall notify the families that they are required to submit invoices or receipts to the Case Management Agency of all purchases made prior to the close of the State Fiscal Year. The Case Management Agency must ensure that all receipts or invoices are collected and maintained from the family, as well as documentation demonstrating that the Family received funding from the Case Management Agency. The Case Management Agency must ensure all receipts or invoices provided by the families contain, at a minimum, Member and/or Family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

3. The Case Management Agency shall submit to the Department, on a form and frequency prescribed by the Department, information which outlines individual Family use of the FSSP.

4. The Case Management Agency shall report only FSSP expenditure data in the format and timeframe as designated by the Department.

8.7561.I FSSP Program Evaluation

1. The Case Management Agency, in cooperation with the local Family Support Council, shall be responsible for evaluating the effectiveness of the FSSP within its defined service area on an annual basis.

2. The evaluation may be based upon a Family satisfaction survey and shall address the following areas:

    a. Effectiveness of outreach/public awareness including:

        i. The demographics of participants in comparison to demographics of the service area; and

        ii. How well the program integrates with other community resources.

    b. Satisfaction and program responsiveness to include:

        i. Ease of access to the program;

        ii. Timeliness of services;

        iii. Effectiveness of services;

        iv. Availability of services;

        v. Responsiveness to Family concerns;

        vi. Overall Family satisfaction with services; and

        vii. Recommendations.

    c. Effective coordination and utilization of funds to include:

        i. Other local services and supports utilized in conjunction with the FSSP; and

        ii. Efficiency of required documentation for receipt of the FSSP.

    d. The Case Management Agency, and participating families as requested, shall cooperate with the Department regarding statewide evaluation and

quality assurance activities, which includes, but is not limited to providing the following information:

i. The maximum amount any one Family may receive through the FSSP during the fiscal year; and

ii. The total number of families to be served during the year.

8.7561.J FSSP Performance and Quality Review

1. The Department shall conduct a Performance and Quality Review of the FSSP to ensure that it complies with the requirements set forth in these rules.

2. A Case Management Agency found to be out of compliance with these rules through the results of the Performance and Quality Review, shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the receipt of the written request from the Department. A Corrective Action Plan shall include, but not limited to:

   a. A detailed description of the action to be taken, including any supporting documentation;

   b. A detailed time frame specifying the actions to be taken;

   c. Employee(s) responsible for implementing the actions; and

   d. The implementation timeframes and a date for completion.

3. The Case Management Agency shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The Agency shall explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the Agency's compliance.

   a. Upon receipt of the Corrective Action Plan, the Department will accept, modify or reject the proposed Corrective Action Plan. Modifications and rejections shall be accompanied by a written explanation.

   b. In the event that the Corrective Action Plan is rejected, the Agency shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

   c. The Agency shall implement the Corrective Action Plan upon acceptance by the Department.

   d. If corrections are not made within the requested timeline and quality specified by the Department, funds may be withheld or suspended.

8.7561.K FSSP Annual Report

1. Each Case Management Agency shall submit an annual FSSP report to the Department by October 1 of each year. The report will contain two sections.

    a. The first section must describe how the Case Management Agency plans to spend the FSSP funds in the current fiscal year and will include:

        i. Description of the outreach/public awareness efforts for the coming year;

        ii. Description of anticipated special projects or activities under the Program Expense service category; and

        iii. Goals with measurable outcomes for any changes to the FSSP.

    b. The second section of the annual report will describe how the FSSP funds were spent in the previous year and must contain:

        i. The program evaluation outcomes for the previous year as described in this section;

        ii. The total amount of funds expended by service category;

        iii. The total number of families served, and the total number of families placed on the waiting list;

        iv. Detailed information for the Program Expense service category to include:

            1) The total number of families that utilized services under the Program Expense category;

            2) The specific services provided; resource library, special projects, training events, social events, or group respite;

            3) How these services enhanced the lives of families in the community and the total number of families who participated in each project; and

            4) The report shall include the total number of staff, total of staff cost, and other costs associated with the Program Expense service category.

        v. A description of how the annual FSSP report was distributed to eligible families; and

vi. The signature of Family Support Council (FSC) members, the FSSP Coordinator, and the Case Management Agency Executive Director.

8.7562 HCBS Telehealth Delivery

1. Telehealth means the broad use of technologies to provide services and supports through HCBS waivers when the Member is in a different location from the provider.

8.7562.A HCBS Telehealth Inclusions

1. HCBS Telehealth may be used to deliver support through the following authorized HCBS Waiver Services:

    a. Adult Day Services; defined at Section 8.7505;

    b. Behavioral Management and Education; defined at Section 8.7508;

    c. Behavioral Therapies - Behavioral Consultation; defined in Section 8.7509;

    d. Behavioral Therapies - Behavioral Counseling, Group, defined in Section 8.7509;

    e. Behavioral Therapies - Behavioral Counseling, Individual, defined in Section 8.7509;

    f. Behavioral Therapies - Behavioral Plan Assessment; defined in Section 8.7509;

    g. Bereavement Counseling; defined at Section 8.7511;

    h. Child and Youth Mentorship; defined at Section 8.7512;

    i. Community Connector; defined at Section 8.7514;

    j. Counseling Services, Family; defined at Section 8.7516;

    k. Counseling Services, Group; set forth at Section 8.7516;

    l. Counseling Services, Individual; set forth at Section 8.7516;

    m. Day Habilitation; described at Section 8.7517;

    n. Expressive Therapy - Art and Play Therapy, Group; defined at Section 8.7521;

o. Expressive Therapy - Art and Play Therapy, Individual; defined at Section 8.7521;

p. Expressive Therapy - Music Therapy, Group; defined at Section 8.7521;

q. Expressive Therapy - Music Therapy, Individual; defined at Section 8.7521;

r. Independent Living Skills Training; defined at Section 8.7529;

s. Mentorship; defined at Section 8.7533;

t. Movement Therapy; defined in Section 8.7534;

u. Palliative/Supportive Care; defined at Section 8.7536;

v. Substance Use Counseling, Family; defined at Section 8.7548;

w. Substance Use Counseling, Individual; defined at Section 8.7548;

x. Supported Employment - Job Coaching, Individual, defined in Section 8.7549;

y. Supported Employment - Job Development, Levels 1-6, Individual, defined at Section 8.7549;

z. Life Skills Training; described at Section 8.7530;

aa. Peer Mentorship; defined at Section 8.7537;

bb. Therapeutic Life Limiting Illness Support, Family; defined at Section 8.7551;

cc. Therapeutic Life Limiting Illness Support, Group; defined at Section 8.7551;

dd. Therapeutic Life Limiting Illness Support, Individual; defined at Section 8.7551; and

ee. Wraparound Services - Wraparound Plan and Prevention and Monitoring; defined at Section 8.7557.

2. HCBS Telehealth may only be used to deliver consultation for the following services:

a. Adaptive Therapeutic Recreational Fees and Equipment, described at Section 8.7504;

b. Assistive Technology; defined in Section 8.7507

c. Home Accessibility Modifications and Adaptations; defined in Section 8.7525 and

d. Vehicle Modifications, defined in Section 8.7554.

e. Providers shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules and may not bill separately for consultation.

8.7562.B HCBS Telehealth Exclusions and Limitations

1. HCBS Telehealth is subject to the limitations of the respective service it supports as referenced in this rule at Section 8.7562.A.

2. HCBS Telehealth is not a duplication of Health First Colorado Telehealth or Telemedicine services.

3. HCBS Telehealth is not permitted to be used for any service not listed in this rule at Section 8.7562.A.

8.7562.C HCBS Telehealth Provider Agency Requirements

1. Providers that choose to use HCBS Telehealth shall develop and make available a written HCBS Telehealth Policy which at a minimum shall include the following:

   a. The Member may refuse telehealth delivery at any time without affecting the Member's right to any future services and without risking the loss or withdrawal of any service to which the Member would otherwise be entitled;

   b. All required and applicable confidentiality protections that apply to the services;

   c. The Member shall have access to all collected information resulting from the services utilized as required by state law;

   d. How utilization of HCBS Telehealth will be made available to those Members who require assistance with accessibility, translation, or have limited visual and/or auditory capabilities;

   e. A contingency plan for service delivery if technology options fail; and,

   f. Provider Agencies shall maintain a copy of the HCBS Telehealth Policy signed by the Member in their records.

2. Provider Agencies shall ensure the use of HCBS Telehealth is the choice of the Member. The HCBS Provider Agency shall maintain a consent form for the use of HCBS Telehealth in the Member's record.

3. Provider Agency shall complete a provider-developed evaluation of the Member and caregiver prior to using HCBS Telehealth services that identifies the Member's ability to participate and outlines any accommodations needed while utilizing HCBS Telehealth.

4. Providers must comply with all HIPAA and confidentiality procedures. HCBS Providers Agencies must be able to use a technology solution that allows real-time interaction with the Member which may include audio, visual and/or tactile technologies.

5. Provider Agencies shall not use HCBS Telehealth to address a Member's emergency needs.

6. Providers Agencies shall use a HIPAA compliant technology solution meeting all privacy requirements.

8.7562.D HCBS Telehealth Reimbursement

1. HCBS Telehealth does not include reimbursement for the purchase or installation of Telehealth equipment or technologies.

2. HCBS Waiver service providers utilizing Telehealth shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules. This includes the prohibition on collecting copayments or charging Members for missing set times for services.

8.7600 Community First Choice

8.7600.A Community First Choice (CFC) Program

1. The Community First Choice Program is funded through an appropriation from the Colorado General Assembly and the Federal government. The CFC program is designed to provide select Home and Community-Based Services and Supports to eligible members on the State Plan.

2. Legal authority as defined in 8.7000.A.

8.7601 General CFC Provisions

1. CFC must be provided to individuals on a statewide basis and in a manner that provides services and supports in the most integrated setting appropriate to meet individuals' needs, and without regard for the individual's age, type or nature of disability, severity of disability, or the form of home and community-based services and supports that the individual requires to lead an independent life.

2. Individuals receiving services through CFC will not be precluded from receiving other home and community-based or long-term care services and supports

through other Medicaid state plan, waiver, grant or demonstration authorities, as long as there is no duplication of services.

3. For the duration of the first year of CFC implementation, Case Managers shall assess current HCBS waiver members for CFC eligibility and services at the time of Continued Stay Review. Case Managers may assess current HCBS waiver members prior to the scheduled Continued Stay Review as warranted by a documented change in the member's needs, diagnosis, or condition.

8.7602 CFC Member Rights and Responsibilities

1. CFC must adhere to all requirements in Home and Community-Based Services Member Rights and Responsibilities as defined in 8.7001 et seq.

8.7603 CFC Definitions

1. Activities of Daily Living is as defined at Section 8.7100.A.1.

2. Assessment is as defined at Section 8.7200.B.1

3. Case Management is as defined at Section 8.7100.A.7.

4. Case Management Agency (CMA) is as defined at Section 8.7100.A.8.

5. Member, for purposes of this Section 8.7600, et seq. means an individual who has met CFC eligibility requirements and has been offered and agreed to receive CFC Services.

6. Community First Choice (CFC) is as defined at Section 8.7001.A.1-A.

7. Continued Stay Review is as defined at Section 8.7100.A.14.

8. Institution is as defined at Section 8.7100.A.39.

9. Level of Care (LOC) is as defined at Section 8.7100.A.43.

10. Level of Care Assessment is as defined at Section 8.7100.A.44.

11. Long-Term Services and Supports (LTSS) is as defined at Section 8.7100.A.47.

12. Medicaid Eligible is as defined at Section 8.7100.A.48.

13. Reassessment is as defined at Section 8.7100.A.55.

14. Referral is as defined at Section 8.7100.A.56.

8.7604 CFC Member Eligibility

1. Individuals of all ages shall be eligible for CFC if they meet Level of Care and financial eligibility criteria.

    a. CFC is available to individuals who, absent the provision of home and community-based attendant services and supports provided under CFC, would require the level of care furnished in a:

        i. Nursing Facility;

        ii. Intermediate Care Facility;

        iii. In Patient Psychiatric Facility for Individuals under 21; or

        iv. Hospital

    b. Financial Eligibility Criteria: To be eligible for the CFC Benefit, an individual shall meet one of the following eligibility groups:

        i. Members shall meet Medicaid Assistance eligibility criteria as stated at Section 8.100 and be enrolled in a Medicaid eligibility group that includes nursing facility services.

            1) CFC does not qualify as a Health First Colorado eligibility group.

        ii. Members eligible for, and enrolled in, an HCBS Waiver as defined in 8.7000, will be eligible for CFC.

2. Level of Care determination process

    a. Individuals shall be referred to the Case Management Agency for an initial Long-Term Services and Supports (LTSS) eligibility determination. The LTSS Level of Care (LOC) eligibility determination screen as defined in 8.401 is used to determine an individual's need for institutional Level of Care.

    b. The state-prescribed Assessment instrument as defined in 8.401 shall measure six defined Activities of Daily Living (ADLs) and the need for supervision for behavioral, executive or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating.

    c. Level of Care Assessments and Reassessments shall be performed by Case Management Agencies and utilize the same instrument in determining the Level of Care for all LTSS programs.

d. The individual must require Long-Term Services and Supports to remain in their own home, in the family residence, or in the community.

e. To utilize CFC Services, the individual must choose to receive services in their home or community.

f. The Case Management Agency shall certify CFC eligibility only for those individuals determined by a Level of Care Assessment to require the Level of Care available in an Institution according to Section 8.401.

3. Institutional Status

a. Members who are residents of Institutions are not eligible for CFC Services while residing in such Institutions.

b. A Member enrolled in CFC and who is admitted to a hospital may not receive CFC Services while residing in the hospital.

i. Providers shall not be reimbursed for CFC Services provided while the member is in a hospital.

c. A Member enrolled in CFC and who is admitted to a nursing facility or ICF-IID may not receive CFC Services while in the nursing facility or Intermediate Care Facilities.

4. Maintenance of CFC Eligibility

a. Reevaluation of the Member to verify Medicaid, financial, and program eligibility is required within twelve months following any previous Assessment. The Continued Stay Review will follow the same procedures set forth at Section 8.401.11-.17(H).

5. Termination

a. The Department shall discontinue a member's enrollment in the CFC benefit when one of the following occurs:

i. The Member no longer meets the CFC Benefit Level of Care and/or Financial eligibility criteria,

ii. The member dies,

iii. The member is admitted for a long-term stay beyond one month in an Institution, or

iv. The member voluntarily withdraws from the CFC program.

8.7605 CFC Case Management Agency Requirements

1. Case Management Agencies must adhere to all Home and Community-based Services requirements as defined at Section 8.7200, et seq.

8.7606 CFC Provider Requirements

1. CFC providers must adhere to all Home and Community-Based Services Provider Agency Requirements as defined at 8.7400, et seq.

8.7607 CFC Covered Services

1. CFC includes the following Home and Community-Based Services as defined at Section 8.7500, et seq. Services include:

    a. CFC Direct Care Services:

        i. Health Maintenance Activities as described at Section 8.7523,

        ii. Homemaker as described at Section 8.7527,

        iii. Personal Care as described at Section 8.7538,

    b. Electronic Monitoring as described at Section 8.7520.

    c. Home Delivered Meals as described at Section 8.7526,

    d. Remote Supports as described at Section 8.7544, and

    e. Transition Setup as described at Section 8.7552.

8.7607.A CFC Direct Care Services Exception Request

1. CFC Direct Care Services Exception Request Definitions

    a. Case Management Supervisor or Alternative Qualified Professional Review means the required first-level review from a Case Management Supervisor or Alternative Qualified Professional to authorize service hours above the Age-Appropriate Task Standards for Children, the Task Standards for Adults, 7 hours per week of the Protective Oversight task in Personal Care, and the Annual CFC Service Soft Caps when indicated by the Direct Care Services Calculator (DCSC).

        i. Case Management Agencies shall develop an internal process for the Supervisor or Alternative Qualified Professional Review which includes deadlines to ensure exceedance requiring a CFC Direct Care Services Department Review Request meets the applicable deadlines.

    b. CFC Direct Care Services Department Review Request means the required process for service authorizations above 7 hours per week of the Protective Oversight Task in Personal Care and/or the Annual CFC Service Soft Caps, as defined at Sections 8.7502.LL, 8.7515.E, 8.7528.E, 8.7538.D, 8.7527.D, and 8.7523.D, for Homemaker, Personal Care, and/or Health Maintenance Activities.

    c. The CFC Direct Care Services Exception Request means a formal request submitted by a Case Manager, with required supporting documentation, seeking a Case Management Supervisor or Alternative Qualified Professional Review or a CFC Direct Care Services Department Review to authorize CFC Direct Care Services in excess of established limits, including applicable maximum Task Standards and service caps. Case Managers must follow the guidelines described in Section 8.7607.A.2 and all additional operational guidance from the Department. Case Management Supervisor or Alternative Qualified Professionals must follow the guidelines described in Section 8.7607.A.3 and all additional operational guidance from the Department. The Department must follow the requirements described in Section 8.7607.A.4.

    d. For the purposes of the CFC Direct Care Services Exception Request, Case Management Supervisor means a Case Management Supervisor that meets the qualifications described in Section 8.7203.A.6 and performs all other supervisory requirements described in Section 8.7204.

    e. For the purposes of the CFC Direct Care Services Exception Request, Alternative Qualified Professional means an alternative professional that is contracted by the Case Management Agency and is qualified to provide a

review within the scope of their license, such as a Registered Nurse or other credentialed professional.

2. CFC Direct Care Services Exception Request Case Manager Responsibilities

   a. Case Managers shall submit for a Case Management Supervisor or Alternative Qualified Professional Review and, if applicable, a CFC Direct Care Services Department Review Request if the Member meets the criteria described in this section and Department operational guidance to exceed the Age-Appropriate Task Standards for Children, the Task Standards for Adults, 7 hours per week of the Protective Oversight Task in Personal Care, and the Annual CFC Service Soft Caps. The Case Manager makes the final determination on submitting a Case Management Supervisor or Alternative Qualified Professional Review request.

   b. Case Managers shall seek a Case Management Supervisor or Alternative Qualified Professional Review and obtain approval from a Case Management Supervisor or Alternative Qualified Professional prior to:

      i. Authorizing hours above the Age-Appropriate Task Standards for Children;

      ii. Authorizing hours above the Task Standards for Adults;

      iii. Submitting a CFC Direct Care Services Department Review Request to exceed 7 hours per week of Protective Oversight Task in Personal Care; and/or

      iv. Submitting a CFC Direct Care Services Department Review Request to exceed Annual CFC Service Soft Caps.

   c. If the total exceedance of the Age-Appropriate Task Standards for Children or Task Standards for Adults is greater than the Annual CFC Service Soft Caps, a CFC Direct Care Services Department Review Request is required.

      i. Case Managers shall submit a CFC Direct Care Services Department Review Request to the Department at least 30 calendar days prior to the service start date after obtaining approval from a Case Management Supervisor or Alternative Qualified Professional. Urgent requests can be submitted when there has been a sudden or unexpected change to the Member’s needs and there is an immediate risk to the Member’s health and safety. Approval from a Case Management Supervisor or Alternative Qualified Professional Review is required prior to submitting an urgent request.

ii. In each CFC Direct Care Services Department Review Request, the Case Manager must include Member-specific documentation, including Assessment findings and service plan details, that demonstrate service appropriateness and compliance with applicable policy.

iii. In each CFC Direct Care Services Department Review Request, the Case Manager must clearly describe the Member's needs, the reason standard limits are insufficient, and how the requested exception supports the Member's health, safety, and community-based living.

iv. Case Managers are responsible for responding to requests for additional information within the 7 calendar days. If additional information is not provided to the Department, the Department will issue an outcome based on the information that was initially provided.

d. Case Managers shall ensure compliance with all Member noticing requirements, as described at 8.7202.R, and issue a Notice of Action for any adverse action taken as a result of the CFC Direct Care Services Exception Request.

e. Case Managers must involve Members in the CFC Direct Care Services Department Review Request by reviewing materials with the Member prior to submitting a CFC Direct Care Services Department Review Request and by providing copies of submitted information, requests for additional information, and CFC Direct Care Services Department Review Request outcomes at the Member's request.

3. CFC Direct Care Services Exception Request Case Management Supervisor or Alternative Qualified Professional Responsibilities

a. The Case Management Supervisor or Alternative Qualified Professional shall conduct a Case Management Supervisor or Alternative Qualified Professional Review for any request to exceed the Age-Appropriate Task Standards for Children or Task Standards for Adults.

b. A Case Management Supervisor or Alternative Qualified Professional must approve a Case Management Supervisor or Alternative Qualified Professional Review for any request for service hours that exceed the Annual CFC Service Soft Caps or a request to exceed more than 7 hours per week of the Protective Oversight Task in Personal Care prior to a Case Manager submitting CFC Direct Care Services Department Review Request. If the Case Management Supervisor or Alternative Qualified Professional Review is denied, the Case Manager shall not submit a CFC Direct Care Services Department Review Request.

c. Case Management Supervisors or Alternative Qualified Professionals shall approve first-level review requests to exceed the Annual CFC Service Soft Caps and requests to exceed the Age-Appropriate Task Standards for Children, and Task Standards for Adults if the record demonstrates all of the following:

i. The care need is documented in the LOC assessment, PCSP, and supporting records;

ii. The request constitutes Extraordinary Care, when applicable;

iii. The request is age-appropriate or exceeds Parental or Legal Guardian of a Minor Responsibility, when applicable;

iv. The request is not duplicative of other covered supports; and

v. The requested additional hours are necessary to ensure health and welfare and support safe community living, including avoiding unnecessary or increased risk of institutionalization.

d. If the Case Management Supervisors or Alternative Qualified Professional Review results in a partial approval or denial, the Case Management Supervisors or Alternative Qualified Professional shall state that Members were only partially approved or denied because certain criteria were not fully satisfied.

e. Supervisors or Alternative Qualified Professionals must document approval/denial in the DCSC and shall sign the DCSC. The completed DCSC and required supporting documentation shall be retained in the Member's record.

4. CFC Direct Care Services Exception Request Department Responsibilities

a. The Department will provide an initial response to the Case Manager regarding the CFC Direct Care Services Department Review Request within 14 calendar days.

i. If additional information is needed for the Department to process the CFC Direct Care Services Department Review Request, a request for additional information will be provided to the submitting Case Manager. If additional information is not provided to the Department within 7 calendar days, the Department will issue an outcome based on the information that was initially provided.

b. The Department will review the submitted CFC Direct Care Services Department Review Request. The Department shall approve additional hours on a case-by-case basis when a demonstrated need is documented and justified by the Member's case manager and the request meets the

review criteria set forth in this section. Any denial or partial approval must include written findings that identify the specific criterion or criteria not met and the evidence relied upon.

c. The CFC Direct Care Services Department Review Request will be reviewed for:

i. Whether the service hours requested are duplicative and/or meet the definition of Extraordinary Care;

ii. The reason Age-Appropriate Task Standards for Children, Task Standards for Adults, and/or Annual CFC Service Soft Caps are insufficient based on the Members assessed need;

iii. How the CFC Direct Care Services Department Review Request maintains the Member’s health and safety and promotes sustainable community-based living; and

iv. Age-appropriateness and for duplication of Parental or Legal Guardian of a Minor Responsibility for requests for children.

d. The Department shall approve additional hours on a case-by-case basis when a demonstrated need is documented and justified by the Member's Case Manager and sufficiently meets the review criteria described in Section 8.7607.A.3.b.

e. The Department shall issue a determination letter for each CFC Direct Care Services Department Review Request unless the CFC Direct Care Services Department Review Request is withdrawn by the Case Manager. Each determination letter shall include:

i. The type of exception that was requested;

ii. The amount requested by the Case Manager;

iii. The approved, partially approved, or denied service hours;

iv. The Member’s approved DCSC-calculated totals by service category and any relevant threshold;

v. A summary of the documentation reviewed, including the PCSP and supporting justification; and

vi. The regulatory citation(s) to support the decision.

f. If the Case Management Supervisors or Alternative Qualified Professional Review results in a partial approval or denial, the Case Management Supervisors or Alternative Qualified Professional shall state that Members

were only partially approved or denied because certain criteria were not fully satisfied.

g. The CFC Direct Care Services Department Review Request process shall be implemented in a uniform manner applied equally to Members statewide, but outcomes shall be based on individual assessed needs and circumstances.

h. The Department may delegate the review of CFC Direct Care Services Department Review Request to a third-party vendor. Any third-party vendor shall be subject to the same requirements applicable to the Department as outlined in this section.

8.7608 CFC Service Delivery Models

1. CFC members may utilize a Provider Agency defined at 8.7001.A.12-B. to receive Personal Care and Homemaker.

2. CFC members may utilize one of the following self-directed service delivery models to receive Personal Care, Homemaker, and/or Health Maintenance Activities:

    a. Consumer Directed Attendant Support Services defined at 8.7515., or

    b. In-Home Support Services defined at 8.7528.

3. CFC members cannot utilize Consumer Directed Attendant Support Services and In-Home Support Services/Provider Agency services simultaneously. In-Home Support and Services can be used in conjunction with Provider Agency services, as long as there is no duplication.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 03/04/2007, 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 03/04/2007, 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]..