

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.500

10 CCR 2505-10 8.500

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

8.500 HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD) WAIVER

8.500.1 This section hereby incorporates the terms and provisions of the federally-approved Home and Community Based Services for Persons with Developmentally Disabilities waiver (HCBS-DD) CO.0007.R06.00. To the extent that the terms of that federally-approved waiver are inconsistent with the provisions of this section, the waiver will control.

8.500.1 DEFINITIONS

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

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

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

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

CLIENT means an individual who has met long term care (LTC) eligibility requirements, is enrolled in and chooses to receive LTC services, and receives LTC services.

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

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 27-10.5-105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-101, C.R.S. *et seq*, and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.

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

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

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

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include 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 mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. § 6000, *et seq.*, shall not apply.

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

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

"Substantial Intellectual Deficits" means an intellectual quotient that is between seventy-one (71) and seventy-five (75) assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (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.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services for persons with Developmental Disabilities (HCBS-DD) within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).

FAMILY means a relationship as it pertains to the client and is defined as:

A mother, father, brother, sister or any combination,

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

An adoptive parent,

One or more individuals to whom legal custody of a client with a developmental disability has been given by a court

A spouse; or,

The client's children.

FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for long term care services as determined by the Department's prescribed instrument.

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

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

GUARDIAN means an individual at least twenty-one years (21) of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Guardianship may include limited, emergency or temporary substitute court appointed guardian but not a guardian ad litem.

Home And Community Based Services (HCBS) Waiver means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR).

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

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

INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) for which the Department makes Medicaid payment under the Medicaid State Plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR) means a publicly or privately operated facility that provides health and habilitation services to a client with mental retardation or related conditions.

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

LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services or the program of all-inclusive care for the elderly (PACE), swing bed and hospital back up program (HBU).

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

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

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

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

OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDs) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

POST ELIGIBILITY TREATMENT OF INCOME (PETI) means the determination of the financial liability of an HCBS Waiver client as defined in 42 CFR 435.217.

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

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional level of care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1 16.200 *et seq.*, that has received program approval to provide HCBS-DD Waiver services.

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

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

RETROSPECTIVE REVIEW means the Department or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service.

SERVICE PLAN means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department and the Operating Agency's rules set forth in 10 CCR 2505-10 Section 8.400.

STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER: means the state owned and operated agency providing home and community based services (HCBS) to clients enrolled in the HCBS waiver for Persons with Developmental Disabilities.

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

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

TARGETED CASE MANAGEMENT (TCM) means a Medicaid State Plan benefit for a target population which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure nonduplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources.

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

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

8.500.2 HCBS-DD WAIVER ADMINISTRATION

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

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

8.500.2.C The HCBS-DD Waiver is operated by the Department of Human Services, Division for Developmental Disabilities under the oversight of the Department of Health Care Policy and Financing.

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

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

8.500.2.F THE HCBS-DD WAIVER:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,
2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments do not to exceed the federally approved capacity, and
4. May limit the enrollment when utilization of the HCBS-DD Waiver program is projected to exceed the spending authority.

8.500.3 GENERAL PROVISIONS

8.500.3.A The following provisions shall apply to the Home and Community Based Services for persons with developmental disabilities (HCBS-DD) waiver.

1. Home and Community Based Services for persons with developmental disabilities (HCBS-DD) shall be provided as an alternative to to ICF-MR services for an client with developmental disabilities.
2. HCBS-DD is waived from the requirements of Section 1902(a)(10)(B) of the Social Security Act concerning comparability of services. The availability of some services may not be consistent throughout the State of Colorado.
3. A client enrolled in the HCBS-DD Waiver shall be eligible for all other Medicaid services for which the client qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-DD Waiver. Services received through the HCBS-DD Waiver may not duplicate services available through the state plan.

8.500.4 CLIENT ELIGIBILITY

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

1. Be determined to have a developmental disability,
2. Be eighteen (18) years of age or older,
3. Require access to services and supports twenty-four (24) hours a day,
4. Meet ICF-MR level of care as determined by the functional needs assessment, and
5. Meet the Medicaid financial determination for LTC eligibility as specified in 10 CCR 2505-10, Section 8.100, *et seq.*

8.500.4.B The client shall maintain eligibility by meeting the criteria as set forth in 10 CCR 2505-10, Section 8.500.6.A.1 and .2 and the following:

1. Receives at least one (1) HCBS waiver service each calendar month.
2. Is not simultaneously enrolled in any other HCBS waiver.
3. Is not residing in a hospital, nursing facility, ICF-MR, correctional facility or other institution.
4. Is served safely in the community with the type and amount of waiver services available and within the federally approved capacity and cost containment limits of the waiver.
5. Resides in a GRSS or IRSS setting.

8.500.4.C When the HCBS-DD Waiver reaches capacity for enrollment, a client determined eligible for the waiver shall be eligible for placement on a wait list in accordance with these rules at 10 CCR 2505-10, Section 8.500.7.

8.500.5 HCBS-DD WAIVER SERVICES

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

1. Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.
 - a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.
 - b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid State Plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.
 - c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.
 - d. Behavioral Services include:
 - i) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.
 - ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall be established.
 - iii) Behavioral consultation services are limited to eighty (80) units per service plan year. One unit is equal to fifteen (15) minutes of service.
 - iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.
 - v) Behavioral Plan Assessment Services are limited to forty (40) units and one (1) assessment per service plan year. One unit is equal to fifteen (15) minutes of service.
 - v). Individual and Group Counseling Services include psychotherapeutic or psycho educational intervention that:
 - 1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

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- 2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.
 - 3) Counseling services are limited to two-hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.
 - vii) Behavioral Line Services include direct one-to-one implementation of the Behavioral Support Plan and is:
 - 1) Under the supervision and oversight of a behavioral consultant,
 - 2) To include acute, short term intervention at the time of enrollment from an institutional setting, or
 - 3) To address an identified challenging behavior of a client at risk of institutional placement and to address an identified challenging behavior that places the client's health and safety or the safety of others at risk.
 - 4) Behavioral Line Services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Requests for an Behavioral Line Services shall be prior authorized in accordance with the Operating Agency's procedures.
 - 2. Day Habilitation Services and Supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.
 - a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence and personal choice.
 - b. Day Habilitation Services and Supports encompass three (3) types of habilitative environments: specialized habilitation services, supported community connections, and prevocational services.
 - c. Specialized Habilitation (SH) services are provided to enable the client to attain the maximum functioning level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services:
 - i) Are provided in a non-integrated setting where a majority of the clients have a disability,
 - ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and
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- iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.
- d. Supported Community Connections Services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:
 - i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan,
 - ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings,
 - iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and
 - iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan.
 - v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.
- e. Prevocational Services are provided to prepare a client for paid community employment. Services consist of teaching concepts including attendance, task completion, problem solving and safety, and are associated with performing compensated work.
 - i) Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.
 - ii) Goals for Prevocational Services are to increase general employment skills and are not primarily directed at teaching job specific skills.
 - iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations.
 - iv) Prevocational Services are provided to support the client to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual service plan demonstrates this need based on an annual assessment.

- v) A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment.
 - vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1401 *et seq.*).
 - f. The number of units available for day habilitation services in combination with prevocational services is four thousand eight hundred (4,800). When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and
 - g. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One unit equals fifteen (15) minutes of service.
- 4. Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.
 - a. Preventative services include:
 - i) Dental insurance premiums and co-pays/co-insurance,
 - ii) Periodic examination and diagnosis,
 - iii) Radiographs when indicated,
 - iv). Non-intravenous sedation,
 - v) Basic and deep cleanings,
 - vi). Mouth guards,
 - vii) Topical fluoride treatment, and
 - X) Retention or recovery of space between teeth when indicated.
 - b. Basic services include:
 - i) Fillings,
 - ii) Root canals,
 - iii) Denture realigning or repairs,
 - iv) Repairs/re-cementing crowns and bridges,
 - v) Non-emergency extractions including simple, surgical, full and partial
 - vi) Treatment of injuries, or

- vii) Restoration or recovery of decayed or fractured teeth
 - c. Major services include:
 - i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.
 - ii) Crowns
 - iii) Bridges
 - iv) Dentures. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval.
 - e. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail.
 - f. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, Section 8011.11 or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client.
 - g. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodontic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:
 - i) Elimination of fractures of the jaw or face,
 - ii) Elimination or treatment of major handicapping malocclusion, or
 - iii) Congenital disfiguring oral deformities.
 - h. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.
 - i. Preventative and basic services are limited to \$2,000 per service plan year. Major services are limited to \$10,000 for the five (5) year renewal period of the waiver.
- 4. Non-Medical Transportation enables clients to gain access to Day Habilitation Services and Supports, Prevocational Services and Supported Employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

- a. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized and documented in the Service Plan.
 - b. Non-Medical Transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-Medical Transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip accessed each way to and from day habilitation and supported employment services.
 - c. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. § 431.53 or transportation services under the Medicaid State Plan, defined at 42 C.F.R. § 440.170(A).
- 5. Residential Habilitation Services and Supports (RHSS) are delivered to ensure the health and safety of the client and to assist in the acquisition, retention or improvement in skills necessary to support the client to live and participate successfully in the community.
 - a. Services may include a combination of lifelong, or extended duration supervision, training or support that is essential to daily community living, including assessment and evaluation, and includes training materials, transportation, fees and supplies.
 - b. The living environment encompasses two (2) types that include individual Residential Services and Supports (IRSS) and Group Residential Services and Supports (GRSS).
 - c. All RHSS environments shall provide sufficient staff to meet the needs of the client as defined in the service plan.
 - d. The following RHSS activities assist clients to reside as independently as possible in the community:
 - i) Self-advocacy training, which may include training to assist in expressing personal preferences, increasing self-representation, increasing self-protection from and reporting of abuse, neglect and exploitation, advocating for individual rights and making increasingly responsible choices,
 - ii) Independent living training, which may include personal care, household services, infant and childcare when the client has a child, and communication skills,
 - iii) Cognitive services, which may include training in money management and personal finances, planning and decision making,
 - iv) Implementation of recommended follow-up counseling, behavioral, or other therapeutic interventions. Implementation of physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.
 - v) Medical and health care services that are integral to meeting the daily needs of the client and include such tasks as routine administration of medications or tending to the needs of clients who are ill or require attention to their medical needs on an ongoing basis,

- vi) Emergency assistance training including developing responses in case of emergencies and prevention planning and training in the use of equipment or technologies used to access emergency response systems,
 - vii) Community access services that explore community services available to all people, natural supports available to the client and develop methods to access additional services, supports, or activities needed by the client,
 - viii) Travel services, which may include providing, arranging, transporting or accompanying the client to services and supports identified in the service plan, and
 - ix) Supervision services which ensure the health and safety of the client or utilize technology for the same purpose.
- e. All direct care staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment and successfully complete a written test and a practical and competency test.
- f. Reimbursement for RHSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of clients or to meet the requirements of the applicable life safety code.
- 6. Specialized Medical Equipment and Supplies include:
 - a. Devices, controls or appliances that enable the client to increase the client's ability to perform activities of daily living,
 - b. Devices, controls or appliances that enable the client to perceive, control or communicate within the client's environment,
 - c. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items,
 - d. Durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address client functional limitations, or
 - e. Necessary medical supplies in excess of Medicaid State Plan limitations or not available under the Medicaid State Plan.
 - f. All items shall meet applicable standards of manufacture, design and installation.
 - g. Specialized medical equipment and supplies exclude those items that are not of direct medical or remedial benefit to the client.
- 7. Supported Employment includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting.

- a. Supported Employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client.
- b. Supported Employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those individuals who are providing services to the client, to the same extent that individuals without disabilities employed in comparable positions would interact.
- c. Supported Employment is work outside of a facility-based site, which is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities.
- d. Supported Employment is provided in community jobs, enclaves or mobile crews.
- e. Group Employment including mobile crews or enclaves shall not exceed eight (8) clients.
- f. Supported Employment includes activities needed to sustain paid work by clients including supervision and training.
- g. When Supported Employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a client as a result of the client's disabilities.
- h. Documentation of the client's application for services through the Colorado Department of Human Services Division of Vocational Rehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education CCT (20 U.S.C. § 1401 *et seq*).
- i. Supported Employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.
- j. Supported Employment shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.
- k. The limitation for Supported Employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.
- l. The following are not a benefit of Supported Employment and shall not be reimbursed:
 - i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,
 - ii) Payments that are distributed to users of supported employment, and
 - iii) Payments for training that are not directly related to a client's supported employment.

8. Vision Services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least twenty-one (21) years of age.
 - a. Lasik and other similar types of procedures are only allowable when:
 - i) The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective.
 - ii) Prior authorized in accordance with Operating Agency procedures.

8.500.6 SERVICE PLAN

8.500.6.A The Case Management Agency shall complete a Service Plan for each client enrolled in the HCBS-DD Waiver in accordance with 10 CCR 2505-10 Section 8.400.

8.500.6.B The Service Plan shall:

1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver services or through other means,
2. Be in accordance with the Department's rules, policies and procedures, and
3. Include updates and revisions at least annually or when warranted by changes in the client's needs.

8.500.6.C The Service Plan shall document that the client has been offered a choice:

1. Between waiver services and institutional care,
2. Among waiver services, and
3. Among qualified providers.

8.500.7 WAITING LIST PROTOCOL

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

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

8.500.7.C When an eligible person is placed on the waiting list for HCBS-DD Waiver services, a written notice of action including information regarding client rights and appeals shall be sent to the person or the person's legal guardian in accordance with the provisions of 10 CCR 2505-10 Section 8.057 *et seq.*

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

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

2. The fourteenth (14) birth date if a child is determined to have a developmental disability by the community centered board prior to the age of fourteen.
- 8.500.7.E As openings become available in the HCBS-DD Waiver program in a designated service area, that community centered board shall report that opening to the Operating Agency.
- 8.500.7.F Persons whose name is on the waiting list shall be considered for enrollment to the HCBS-DD Waiver in order of placement date on the waiting list. Exceptions to this requirement shall be limited to:
1. An emergency situation where the health and safety of the person or others is endangered and the emergency cannot be resolved in another way. Emergencies are defined by the following criteria:
 - a. Homeless: the person does not have a place to live or is in imminent danger of losing the person's place of abode.
 - b. Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in the person's present living situation and the person's health, safety or well-being is in serious jeopardy.
 - c. Danger to others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure safety of the person in the community.
 - d. Danger to self: a person's medical, psychiatric or behavioral challenges are such that the person is seriously injuring/harming self or is in imminent danger of doing so.
- 8.500.7.G Enrollments may be reserved to meet statewide priorities that may include:
1. A person who is eligible for the HCBS-DD Waiver and is no longer eligible for services in the foster care system due to an age that exceeds the foster care system limits,
 2. Persons who reside in long term care institutional settings who are eligible for the HCBS-DD Waiver and have a requested to be placed in a community setting, and
 3. Persons who are in an emergency situation.
- 8.500.7.H Enrollments shall be authorized to persons based on the criteria set forth by the general assembly in appropriations when applicable.

8.500.8 CLIENT RESPONSIBILITIES

- 8.500.8.A A client or guardian is responsible to:
1. Provide accurate information regarding the client's ability to complete activities of daily living,
 2. Assist in promoting the client's independence,
 3. Cooperate in the determination of financial eligibility for Medicaid,
 4. Notify the case manager within thirty (30) days after:

- a. Changes in the client's support system, medical, physical or psychological condition or living situation including any hospitalizations, emergency room admissions, placement to a nursing home or intermediate care facility for the mentally retarded (ICF-MR),
- b. The client has not received an HCBS waiver service during one (1) month,
- c. Changes in the client's care needs,
- d. Problems with receiving HCBS Waiver services,
- e. Changes that may affect Medicaid financial eligibility including prompt reporting of changes in income or assets.

8.500.9 PROVIDER REQUIREMENTS

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

- 1. Conform to all state established standards for the specific services they provide under HCBS-DD,
- 2. Maintain program approval and certification from the Operating Agency,
- 3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,
- 4. Discontinue services to a client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services,
- 5. Have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on confidentiality of information at § 25.5-1-116, C.R.S., as amended,
- 6. When applicable, maintain the required licenses from the Colorado Department of Public Health and Environment, and
- 7. Maintain client records to substantiate claims for reimbursement according to Medicaid standards.
- 8. HCBS-DD providers shall comply with:
 - a. All applicable provisions of Section 27-10.5, C.R.S. et seq, and all rules and regulations as set forth in 2 CCR 503-1, Section 16 et seq.,
 - b. All federal program reviews and financial audits of the HCBS-DD Waiver services,
 - c. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,
 - d. Requests from the County Departments of Social/Human Services to access records of clients receiving services held by Case Management Agencies as required to determine and re-determine Medicaid eligibility

- e. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-DD Waiver, and
- f. Requests by the Case Management Agency to monitor service delivery through targeted case management activities.

8.500.10 TERMINATION OR DENIAL OF HCBS-DD MEDICAID PROVIDER AGREEMENTS

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

- 1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq.*
- 2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-DD services.
- 3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.
- 4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior client notification.
- 5. The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.
- 6. Emergency termination of any provider agreement shall be in accordance with the procedures at 10 CCR 2505-10, Section 8.050.

8.500.11 ORGANIZED HEALTH CARE DELIVERY SYSTEM

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

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

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

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

8.500.11.E The OCHDS shall:

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

2. Ensure that services are delivered according to the waiver definitions and as identified in the client's service plan,
3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and
4. Monitor the health and safety for HCBS clients receiving services from a subcontractor.

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

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,
2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,
3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients,
4. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and Operating Agency procedures,
 - a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.
5. Collect and maintain the data used to develop provider rates and ensure that the data includes costs for services to address the client's needs, that are allowable activities within the HCBS service definition and that supports the established rate,
6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency or Centers for Medicare and Medicaid Services (CMS), and
7. Report by August 31st of each year, the names, rates and total payments made to the contractor.

8.500.12 PRIOR AUTHORIZATION REQUESTS

8.500.12.A Prior Authorization Requests (PAR) shall be in accordance with 10 CCR 2505-10, Section 8.058.

8.500.12.B A PAR shall be submitted to the Operating Agency through the Department's designated information management system.

8.500.12.C The Case Management Agency shall comply with the policies and procedures for the PAR review process as set forth by the Department and the Operating Agency.

8.500.12.D The Case Management Agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:

1. Consistent with the client's documented medical condition and functional capacity as indicated in the functional needs assessment,
2. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved waiver, and
3. Not duplicative of another authorized service, including services provided through:
 - a. Medicaid State Plan benefits,
 - b. Third party resources,
 - c. Natural supports,
 - d. Charitable organizations, or
 - e. Other public assistance programs.
4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10, Section 8.058.4.

8.500.13 RETROSPECTIVE REVIEW PROCESS

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

1. Identified in the service plan are based on the client's identified needs as stated in the functional needs assessment,
2. Have been requested and approved prior to the delivery of services,
3. Provided to a client are in accordance with the service plan, and
4. Provided within the specified HCBS service definition in the federally approved HCBS-DD Waiver,

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

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

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

8.500.14 PROVIDER REIMBURSEMENT

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

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- 8.500.14.B Provider claims for reimbursement shall be made only when the following conditions are met:
1. Services are provided by a qualified provider as specified in the federally-approved HCBS-DD Waiver,
 2. Services have been prior authorized,
 3. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the client's service plan, and
 4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.
- 8.500.14.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.
- 8.500.14.D When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.
- 8.500.14.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.
- 8.500.14.F For private providers payment is based on a statewide fee schedule.
- 8.500.14.G Reimbursement paid to State or local government HCBS waiver providers differs from the amount paid to private providers of the same service. No public provider may receive payments in the aggregate that exceed its actual costs of providing HCBS waiver services.
1. Reimbursement paid to State and local government HCBS waiver providers shall not exceed actual costs. All State and local HCBS waiver providers must submit an annual cost report for HCBS waiver services.
 2. Actual costs will be determined on the basis of the information on the HCBS waiver cost report and obtained by the Department or its designee for the purposes of cost auditing.
 - a. The costs submitted by the provider for the most recent available final cost report for a 12 month period shall be used to determine the interim rates for the ensuing 12 month period effective July 1 of each year.
 - i. The interim rate will be calculated as total reported costs divided by total units per HCBS waiver service.
 - ii. An interim rate shall be determined for each HCBS waiver service provided.
 - iii. The most recent available final cost report will be used to set the next fiscal year's interim rates.
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- b. Reimbursement to State and local government HCBS waiver providers shall be adjusted retroactively after the close of each 12 month period.
 - c. Total costs submitted by the provider shall be reviewed by the Department or its designee and result in a total allowable cost.
 - d. The Department will determine the total interim payment through the MMIS.
 - e. The Department will reconcile interim payments to the total allowable and make adjustments to payments as necessary. Interim payments shall be paid through the MMIS.
- 3. Submission of the HCBS waiver cost report shall occur annually for costs incurred during the prior fiscal year.
 - a. The cost report for HCBS waiver services must be submitted to the Department annually on October 31 to reflect costs from July 1-June 30.
 - b. The cost report will determine the final adjustment to payment for the period for which the costs were reported.
 - c. Reconciliation to align the fiscal year reimbursement with actual fiscal year costs after the close of each fiscal year shall be determined by the Department annually.
 - e. A State or local government HCBS waiver provider may request an extension of time to submit the cost report. The request for extension shall:
 - i. Be in writing and shall be submitted to the Department.
 - ii. Document the reason for failure to comply.
 - iii. Be submitted no later than ten (10) working days prior to the due date for submission of the cost report.
 - f. Failure of a State or local government HCBS waiver provider to submit the HCBS waiver cost report by October 31 shall result in the Department withholding all warrants not yet released to the provider as described below:
 - i. When a State or local government HCBS waiver provider fails to submit a complete and auditable HCBS waiver cost report on time, the HCBS waiver cost report shall be returned to the facility with written notification that it is unacceptable.
 - 1. The State or local government HCBS waiver provider shall have either 30 days from the date of the notice or until the end of the cost report submission period, whichever is later, to submit a corrected HCBS waiver cost report.

2. If the corrected HCBS waiver cost report is still determined to be incomplete or un-auditable, the State or local government HCBS waiver provider shall be given written notification that it shall, at its own expense submit a HCBS waiver cost report prepared by a Certified Public Accountant (CPA). The CPA shall certify that the report is in compliance with all Department rules and shall give an opinion of fairness of presentation of operating results or revenues and expenses.
 3. The Department may withhold all warrants not yet released to the provider when the original cost report submission period and 30-day extension have expired and an auditable HCBS waiver cost report has not been submitted.
 - ii. If the audit of the HCBS waiver cost report is delayed by the state or local government HCBS waiver provider's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall mean failure to provide documents, personnel or other resources within its control and necessary for the completion of the audit.
4. Non-allowable costs for State and local government providers offering HCBS waiver services include:
 - a. Room and Board;
 - b. Costs which have been allocated to an ICF/IID;
 - c. Costs for which there is either no supporting documentation or for which the supporting documentation is not sufficient to validate the costs;
 - d. Costs for services that are available through the Medicaid State Plan or provided on an HCBS waiver other than the HCBS waiver for Persons with Developmental Disabilities;
 - e. Costs for services that are not authorized on an approved HCBS waiver for Persons with Developmental Disabilities PAR.
 - f. Costs for services that are not authorized by the Department as an HCBS waiver service;
 - g. Costs which are not reasonable, necessary, and client related.
5. Adjustment(s) to the HCBS waiver cost report shall be made by the Department's contract auditor to remove reported costs that are non-allowable.
 - a. Following the completion of an audit of the cost report the Department or its contract auditor shall notify the affected State or local government HCBS waiver provider of any proposed adjustment(s) to the costs reported on the HCBS waiver cost report and include the basis of the proposed adjustment(s).

- b. The provider may submit additional documentation in response to a proposed adjustment. The Department or its contract auditor must receive the additional documentation or other supporting information from the provider within 14 calendar days of the date of the proposed adjustments letter or the documentation will not be considered.
- c. The Department may grant a reasonable period, no longer than 30 calendar days, for the provider to submit such documents and information, when necessary and appropriate, given the providers' particular circumstances.
- d. The Department or its contract auditor shall complete the audit of the cost report within 30 days of the submission of documentation by the provider.

8.500.15 INDIVIDUAL RIGHTS

8.500.15.A Individual rights shall be in accordance with 27-10.5-101 C.R.S. *et seq.*

8.500.16 APPEAL RIGHTS

8.500.16.A The CCB shall provide the long term care notice of action form to applicants and clients within ten (10) business days regarding their appeal rights in accordance with 10 CCR 2505-10, Section 8.057 *et seq.* When:

- 1. The applicant is determined to not have a developmental disability,
- 2. The applicant is found eligible or ineligible for LTC services,
- 3. The applicant is determined eligible or ineligible for placement on a waitlist for Medicaid LTC services,
- 4. An adverse action occurs that affects the client's waiver enrollment status,
- 5. An adverse action occurs that affects the provision of the client's waiver services, or
- 6. The applicant or client requests such information.

8.500.16.B The CCB shall represent their decision at the Office of Administrative Courts as described in 10 CCR 2505-10, Section 8.057 *et seq.* when CCB has made a denial or adverse action against a client.

8.500.16.C The CCB shall notify all providers in the client's service plan within ten (10) business day of the adverse action.

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

8.500.16.E The applicant or client shall be informed of an adverse action if the client is determined ineligible as set forth in client eligibility and the following:

- 1. The client cannot be served safely within the cost containment as identified in the HCBS-DD Waiver,
- 2. The client is placed in an institution for treatment with a duration that continues for more than thirty (30) days,

3. The client is detained or resides in a correctional facility, or
 4. The client enters an institute for mental health with a duration that continues for more than thirty (30) days.
- 8.500.16.F The client shall be notified, pursuant to 10 CCR 2502-10 Section 8.057.2.A, when the following results in an adverse action that does not relate to HCBS-DD Waiver client eligibility requirements:
1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the functional needs assessment,
 2. A waiver service is terminated or denied because is not available through the current federally-approved waiver,
 3. A service plan or waiver service exceeds the limits as set forth in the in the federally-approved waiver,
 4. The client or client representative has failed to schedule an appointment for the functional needs assessment, service plan, or six (6) month visit with the case manager two (2) times in a thirty (30) day consecutive period,
 5. The client or client representative has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,
 6. The client enrolls in a different long term care program, or
 7. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.
 - a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to Income Maintenance Staff Manual at 9 CCR 2503-1, Section 3.140.2., shall not be terminated unless one or more of the other client eligibility criteria are no longer met.
 8. The client voluntarily withdraws from the waiver program. The client shall be terminated from the waiver effective upon the day after the date on which the client's request is documented.
- 8.500.16.G The CCB shall not send the LTC notice of action form when the basis for termination is death of the client, but shall document the event in the client record. The date of action shall be the day after the date of death.

8.500.17 QUALITY ASSURANCE

- 8.500.17.A The monitoring HCBS-DD Waiver services and the health and well-being of service recipients shall be the responsibility of the Operating Agency, under the oversight of the Department.
- 8.500.17.B The Operating Agency, shall conduct reviews of each agency providing HCBS-DD Waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department or Operating Agency. The review shall apply rules and standards developed for programs serving individuals with developmental disabilities.

8.500.17.C The Operating Agency shall maintain or cause to be maintained for three (3) years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-DD Waiver programs or the delivery of services. The Department shall have access to these records at any reasonable time.

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

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

8.500.18 CLIENT PAYMENT - POST ELIGIBILITY TREATMENT OF INCOME

8.500.18.A A client who is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard at 10 CCR 2505-10 § 8.100.7.A, is required to pay a portion of the client's income toward the cost of the client's HCBS-DD services after allowable income deductions.

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

1. Be calculated by the Case Management Agency using the form specified by the Operating Agency.
2. Be calculated during the client's initial or continued stay review for HCB-DD services;
3. Be recomputed as often as needed, by the case management agency in order to ensure the client's continued eligibility for the HCBS-DD waiver;

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

1. A maintenance allowance equal to 300% the current and/SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty five dollars (\$245) per month;
2. For a client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and
3. For a client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate AFDC grant level; and
4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:
 - a. Health insurance premiums (other than Medicare), deductibles. or coinsurance charges (including Medicaid copayments); and
 - b. Necessary medical or remedial care recognized under State law but not covered under the Medicaid State Plan.

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

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

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

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

8.500.90 DEFINITIONS

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

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

APPLICANT means an individual who is seeking a Long Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in a assessment.

CLIENT means an individual who has met Long Term Care (LTC) eligibility requirements, is enrolled in and chooses to receive LTC services, and subsequently receives LTC services.

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

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 27-10.5105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-105, C.R.S. *et seq*, and provides authorized services and supports to such persons either directly or by purchasing such services and supports from service agencies.

CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option set forth at section 8.510. *et. seq*

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

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

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

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include 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 mental retardation. Unless otherwise specifically stated, the federal definition of "Developmental Disability" found in 42 U.S.C., Section 6000, *et seq.*, shall not apply.

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

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

Substantial intellectual deficits means an intellectual quotient that is between seventy one (71) and seventy five (75) assuming a scale with a mean of one hundred 100 and a standard deviation of fifteen (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.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services-Supported Living Services (HCBS-SLS) to persons with developmental disabilities within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of the Medicaid State Plan for Medicaid eligible children up to age 21.

FAMILY means a relationship as it pertains to the client and includes the following:

A mother, father, brother, sister or,

Extended blood relatives such as grandparent, aunt or uncle

Cousins or,

An adoptive parent; or,

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

A spouse; or

The client's children.

FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for Long Term Care services as determined by the Department's prescribed instrument.

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the uniform long term care instrument and medical verification on the professional medical information page to determine if the applicant or client meets the institutional level of care (LOC).

GUARDIAN means an individual at least twenty-one (21) years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute guardian but not a guardian ad litem.

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the social security act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR).

INSTITUTION means a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR) for which the Department makes Medicaid payment under the State plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR) means a public or private facility that provides health and habilitation services to a client with developmental disabilities or related conditions.

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

LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a client must require in order to receive services in an institutional setting under the state plan. **LONG TERM CARE (LTC) SERVICES** means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services, swing bed and hospital back up program (HBU).

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

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

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

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

OPERATING AGENCY means the Department of HEALTH CARE POLICY AND FINANCING, IN THE DIVISION FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, which manages the operations of the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDs) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services for the Developmentally Disabled (HCBS-DD), Home and Community Based Services Supported Living Services (HCBS-SLS) and Home and Community Based Services Children's Extensive Support (HCBS-CES) waivers.

POST ELIGIBILITY TREATMENT OF INCOME (PETI) means the determination of the financial liability of an HCBS waiver client as defined in 42 C.F.R 435.217.

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, the Operating Agency, a State fiscal agent or the case management agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional level of care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1, Section 16.200 *et seq.*, that has received program approval to provide HCBS-SLS services.

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

Reimbursement rates means the maximum allowable Medicaid reimbursement to a provider for each unit of service.

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

RETROSPECTIVE REVIEW means the Department or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service

SERVICE DELIVERY OPTION MEANS THE METHOD BY WHICH DIRECT SERVICES ARE PROVIDED FOR A PARTICIPANT. THOSE OPTIONS INCLUDE: A) BY AN AGENCY .B) PARTICIPANT DIRECTED.

SERVICE PLAN means the written document that specifies identified and needed services to include Medicaid eligible and non-Medicaid eligible services, regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department and the Operating Agency's rules set forth in 10 CCR 2505-10, Section 8.400.

SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs. Each SPAL is determined by the Department and Operating Agency based on the annual appropriation for the HCBS-SLS waiver, the number of clients in each level, and projected utilization.

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

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

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

TARGETED CASE MANAGEMENT (TCM) means a Medicaid State plan benefit for a target population which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources such as medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources.

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

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

8.500.91 HCBS-SLS WAIVER ADMINISTRATION

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

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

8.500.10.C The HCBS-SLS Waiver is operated by the Department of Human Services, Division for Developmental Disabilities under the oversight of the Department of Health Care Policy and Financing.

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

8.500.91.F The HCBS-SLS Waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,
2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments into the HCBS-SLS Waiver do not exceed the federally approved waiver capacity, and
4. May limit the enrollment when utilization of the HCBS-SLS Waiver program is projected to exceed the spending authority.

8.500.92 GENERAL PROVISIONS

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

1. HCBS-SLS shall be provided as an alternative to ICF-MR services for an eligible client with developmental disabilities.
2. HCBS-SLS is waived from the requirements of Section 1902(a)(10)(b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the State of Colorado.
3. A client enrolled in the HCBS-SLS Waiver shall be eligible for all other Medicaid services for which the client qualifies and shall first access all benefits available under the Medicaid State plan or Medicaid EPSDT prior to accessing services under the HCBS-SLS Waiver. Services received through the HCBS-SLS Waiver may not duplicate services available through the State Plan

8.500.93 CLIENT ELIGIBILITY

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

1. Be determined to have a developmental disability
2. Be eighteen (18) years of age or older,
3. Does not require twenty-four (24) hour supervision on a continuous basis which is reimbursed as a HCBS-SLS service,
4. Is served safely in the community with the type or amount of HCBS-SLS waiver services available and within the federally approved capacity and cost containment limits of the waiver,
5. Meet ICF-MR level of care as determined by the Functional Needs Assessment
6. Meet the Medicaid financial determination for LTC eligibility as specified at 10 CCR 2505-10, Section 8.100 *et seq.*; and,
7. Reside in an eligible HCBS-SLS setting. SLS settings are the client's residence, which is defined as the following:
 - a. A living arrangement, which the client owns, rents or leases in own name,
 - b. The home where the client lives with the client's family or legal guardian, or
 - c. A living arrangement of no more than three (3) persons receiving HCBS-SLS residing in one household, unless they are all members of the same family.

8. The client shall maintain eligibility by continuing to meet the HCBS-SLS eligibility requirements and the following:
 - a. Receives at least one (1) HCB-SLS waiver service each calendar month,
 - b. Is not simultaneously enrolled in any other HCBS waiver, and
 - c. Is not residing in a hospital, nursing facility, ICF-MR, correctional facility or other institution.
9. When the HCBS-SLS waiver reaches capacity for enrollment, a client determined eligible for a waiver shall be placed on a wait list in accordance with these rules.10 CCR 2505-10, Section 8.500.96 et seq.

8.500.94 HCBS-SLS WAIVER SERVICES

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

1. Assistive technology includes services, supports or devices that assist a client to increase, maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:
 - a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,
 - b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,
 - c. Training or technical assistance for the client, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives of the client,
 - d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-SLS Waiver, and
 - e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency procedure.
 - f. Assistive technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan or third party resource.
 - g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.
 - h. When the expected cost is to exceed \$2,500 per device three estimates shall be obtained and maintained in the case record.
 - i. Training and technical assistance shall be time limited, goal specific and outcome focused.

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- j. The following items and services are specifically excluded under HCBS-SLS waiver and not eligible for reimbursement:
 - i) Purchase, training or maintenance of service animals,
 - ii) Computers,
 - iii) Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of game,
 - iv) Training or adaptation directly related to a school or home educational goal or curriculum.
 - k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed \$10,000 over the five year life of the waiver unless an exception is applied for and approved. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures within thirty (30) days of the request.
2. Behavioral services are services related to the client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.
- a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.
 - b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.
 - c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.
 - d. Behavioral Services:
 - i) Behavioral consultation services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management.
 - ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall be established.
 - iii). Behavioral consultation services are limited to eighty (80) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.
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- iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.
 - v) Behavioral plan assessment services are limited to forty (40) units and one (1) assessment per service plan year. One (1) unit is equal to fifteen (15) minutes of service.
 - vi) Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:
 - 1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and
 - 2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.
 - 3) Counseling services are limited to two hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.
 - vii) Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and are:
 - 1) Under the supervision and oversight of a behavioral consultant,
 - 2) To include acute, short term intervention at the time of enrollment from an institutional setting, or
 - 3) To address an identified challenging behavior of a client at risk of institutional placement, and that places the client's health and safety or the safety of others at risk
 - 4) Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. All behavioral line services shall be prior authorized in accordance with Operating Agency procedure
- 3. Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.
 - a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.
 - b. Day habilitation services and supports encompass three (3) types of habilitative environments; specialized habilitation services, supported community connections, and prevocational services.

- c. Specialized habilitation (SH) services are provided to enable the client to attain the maximum functional level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services:
 - i) Are provided in a non-integrated setting where a majority of the clients have a disability,
 - ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and
 - iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.
- d. Supported community connections services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:
 - i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan,
 - ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings,
 - iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and
 - iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan.
 - v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.
- e. Prevocational services are provided to prepare a client for paid community employment. Services include teaching concepts including attendance, task completion, problem solving and safety and are associated with performing compensated work.
 - i) Prevocational services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.
 - ii) Goals for prevocational services are to increase general employment skills and are not primarily directed at teaching job specific skills.

- iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than 50 percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor regulations.
 - iv) Prevocational services are provided to support the client to obtain paid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need based on an annual assessment.
 - v) A comprehensive assessment and review for each person receiving prevocational services shall occur at least once every five years to determine whether or not the person has developed the skills necessary for paid community employment.
 - vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under section 110 of the rehabilitation act of 1973 or the Individuals with Educational Disabilities Act (20 U.S.C. Section 1401 *et seq*).
 - f. Day habilitation services are limited to seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.
 - g. The number of units available for day habilitation services in combination with prevocational services and supported employment shall not exceed seven thousand one hundred and twelve (7,112) units.
4. Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.
- a. Preventative services include:
 - i) Dental insurance premiums and co-payments
 - ii) Periodic examination and diagnosis,
 - iii) Radiographs when indicated,
 - iv) Non-intravenous sedation,
 - v) Basic and deep cleanings,
 - vi) Mouth guards,
 - vii) Topical fluoride treatment,
 - viii) Retention or recovery of space between teeth when indicated, and
 - b. Basic services include:
 - i) Fillings,
 - ii) Root canals,

- iii) Denture realigning or repairs,
 - iv) Repairs/re-cementing crowns and bridges,
 - v) Non-emergency extractions including simple, surgical, full and partial,
 - vi) Treatment of injuries, or
 - vii) Restoration or recovery of decayed or fractured teeth,
- c. Major services include:
- i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.
 - ii) Crowns
 - iii) Bridges
 - iv) Dentures
- d. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, 8011.11 or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client
- e. Implants shall not be a benefit for clients who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users.
- f. Subsequent implants are not a covered service when prior implants fail.
- g. Full mouth implants or crowns are not covered.
- h. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodontic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:
- i) Elimination of fractures of the jaw or face,
 - ii) Elimination or treatment of major handicapping malocclusion, or
 - iii) Congenital disfiguring oral deformities.
- i. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.
- j. Preventative and basic services are limited to two thousand (\$2,000) per service plan year. Major services are limited to ten thousand (\$10,000) for the five (5) year renewal period of the waiver.

5. Home Accessibility Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health, and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include:
 - a. The installation of ramps,
 - b. Widening or modification of doorways,
 - c. Modification of bathroom facilities to allow accessibility and assist with needs in activities of daily living,
 - d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment supplies that are necessary for the welfare of the client, and
 - e. Safety enhancing supports such as basic fences, door and window alarms.
 - f. The following items are specifically excluded from home accessibility adaptations and shall not be reimbursed:
 - i) Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,
 - ii) Carpeting,
 - iii) Roof repair,
 - iv). Central air conditioning,
 - v) Air duct cleaning,
 - vi) Whole house humidifiers,
 - vii) Whole house air purifiers,
 - viii) Installation or repair of driveways and sidewalks,
 - ix) Monthly or ongoing home security monitoring fees,
 - x) Home furnishings of any type, and
 - xi) Luxury upgrades.
 - g. When the HCBS-SLS waiver has provided modifications to the client's home and the client moves to another home, those modifications shall not be duplicated in the new residence unless prior authorized in accordance with Operating Agency procedures.

Adaptation to rental units, when the adaptation is not portable and cannot move with the client shall not be covered unless prior authorized in accordance with Operating Agency procedures.

- h. 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.
 - i. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agency procedures.
 - j. All devices and adaptations shall be provided in accordance with applicable state or local building codes or applicable standards of manufacturing, design and installation. Medicaid state plan, EPSDT or third party resources shall be utilized prior to authorization of waiver services.
 - k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed \$10,000 over the five-year life of the waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health, and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with Operating Agency procedure.
- 6. Homemaker services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of homemaker services:
 - a. Basic homemaker services include cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.
 - i) Assistance may take the form of hands-on assistance including actually performing a task for the client or cueing to prompt the client to perform a task.
 - ii) Lawn care, snow removal, air duct cleaning, and animal care are specifically excluded under the HCBS-SLS waiver and shall not be reimbursed.
 - b. Enhanced homemaker services includes basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning
 - i) Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.
 - ii) The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task:
 - 1) When such support is incidental to the habilitative services being provided, and

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- 2) To increase the independence of the client,
 - iii) Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the client.
 - iv) Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.
 - 7. Mentorship services are provided to clients to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising and include:
 - a. Assistance in interviewing potential providers,
 - b. Assistance in understanding complicated health and safety issues,
 - c. Assistance with participation on private and public boards, advisory groups and commissions, and
 - d. Training in child and infant care for clients who are parenting children.
 - e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.
 - f. Mentorship services are limited to one hundred and ninety two (192) units (forty eight (48) hours) per service plan year. One (1) unit is equal to fifteen (15) minutes.
 - g. Units to provide training to clients for child and infant care shall be prior authorized beyond the one hundred and ninety two (192) units per service plan year in accordance with Operating Agency procedures.
 - 8. Non-medical transportation services enable clients to gain access to day habilitation, prevocational and supported employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.
 - a. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the service plan.
 - b. Non-medical transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-medical transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip charge assessed each way to and from day habilitation and supported employment services.
 - c. Transportation provided to destinations other than to day program or supported employment is limited to four (4) trips per week reimbursed at mileage band one
 - d. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. the applicable mileage band. Non-medical transportation Medicaid State Plan, defined at 42 C.F.R. §440.170(A).

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9. Personal Emergency Response System (PERS) is an electronic device that enables clients to secure help in an emergency. The client may also wear a portable “help” button to allow for mobility. The system is connected to the client’s phone and programmed to a signal a response center once a “help” button is activated. The response center is staffed by trained professionals.
 - a. The client and the client’s case manager shall develop a protocol for identifying who should to be contacted if the system is activated.
 10. Personal Care is assistance to enable a client to accomplish tasks that the client would complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task. Personal care services include:
 - a. PERSONAL CARE SERVICES INCLUDE:
 - i) Assistance with basic self-care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.
 - ii) Assistance with money management,
 - iii) Assistance with menu planning and grocery shopping, and
 - iv) Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments, support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor’s orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.
 - b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.
 - c. If the annual functional needs assessment identifies a possible need for skilled care: then the client shall obtain a home health assessment.
 - I. THE CLIENT SHALL OBTAIN A HOME HEALTH ASSESSMENT, OR
 - II. THE CLIENT SHALL BE INFORMED OF THE OPTION TO DIRECT HIS/HER HEALTH MAINTENANCE ACTIVITIES PURSUANT TO SECTION 8.510.12, ET SEQ.
 11. Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or behavioral need. Professional services include:
 - a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.
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- b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.
 - c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes watsu.
 - d. Professional services can be reimbursed only when:
 - i) The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,
 - ii) The intervention is related to an identified medical or behavioral need, and
 - iii) The Medicaid State plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.
 - e. A pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes.
 - f. The following services are excluded under the HCBS Waiver from reimbursement;
 - i) Acupuncture,
 - ii) Chiropractic care,
 - iii) Fitness trainer
 - iv) Equine therapy,
 - v) Art therapy,
 - vi) Warm water therapy,
 - vii) Experimental treatments or therapies, and.
 - viii) Yoga.
12. Respite service is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.
- a. Respite may be provided:
 - i) In the client's home and private place of residence,
 - ii) The private residence of a respite care provider, or
 - iii) In the community.

- b. Respite shall be provided according to individual or group rates as defined below:
 - i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.
 - ii) Individual Day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period.
 - iii) Overnight Group: the client receives respite in a setting which is defined as a facility that offers 24 hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.
 - iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.
 - c. The following limitations to respite services shall apply:
 - i) Federal financial participation shall not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1, Section 16.221. by the state that is not a private residence.
 - ii) Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.
 - iii) Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight group respite rate shall not exceed the respite daily rate.
13. Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized medical equipment and supplies include:
- a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;
 - b. Specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing;
 - c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-SLS waiver.
 - d. The following items are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement:

- i) Items that are not of direct medical or remedial benefit to the client are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement. These include but are not limited to; vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.
- 14. Supported Employment services includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting.
 - a. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client.
 - b. Supported employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those individuals who are providing services to the client, to the same extent that individuals without disabilities employed in comparable positions would interact.
 - c. Supported employment is work outside of a facility-based site, that is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities,
 - d. Supported employment is provided in community jobs, enclaves or mobile crews.
 - e. Group employment including mobile crews or enclaves shall not exceed eight clients.
 - f. Supported employment includes activities needed to sustain paid work by clients including supervision and training.
 - g. When supported employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a client as a result of the client's disabilities.
 - h. Documentation of the client's application for services through the Colorado Department of Human Services Division for Vocational Rehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. § 1401et seq).
 - i. Supported employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.
 - j. Supported employment shall not take the place of nor shall it duplicate services received through the Division for Vocational Rehabilitation.
 - k. The limitation for supported employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

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- I. The following are not a benefit of supported employment and shall not be reimbursed:
 - i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,
 - ii) Payments that are distributed to users of supported employment, and
 - iii) Payments for training that are not directly related to a client's supported employment.
 - 15. Vehicle modifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation; to accommodate the special needs of the client; are necessary to enable the client to integrate more fully into the community; and to ensure the health and safety of the client.
 - a. Upkeep and maintenance of the modifications are allowable services.
 - b. Items and services specifically excluded from reimbursement under the HCBS Waiver include:
 - i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client,
 - ii) Purchase or lease of a vehicle, and
 - iii) Typical and regularly scheduled upkeep and maintenance of a vehicle.
 - c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed \$10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.
 - 16. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least 21 years of age
 - a. Lasik and other similar types of procedures are only allowable when:
 - b. The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and
 - c. Prior authorized in accordance with Operating Agency procedures.

17. HEALTH MAINTENANCE ACTIVITIES ARE AVAILABLE ONLY AS A PARTICIPANT DIRECTED SUPPORTED LIVING SERVICE IN ACCORDANCE WITH 8.500.94.B. HEALTH MAINTENANCE ACTIVITIES MEANS ROUTINE AND REPETITIVE HEALTH RELATED TASKS FURNISHED TO AN ELIGIBLE CLIENT IN THE COMMUNITY OR IN THE CLIENT'S HOME, WHICH ARE NECESSARY FOR HEALTH AND NORMAL BODILY FUNCTIONING THAT A PERSON WITH A DISABILITY IS UNABLE TO PHYSICALLY CARRY OUT. SERVICES MAY INCLUDE:
- a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection. Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional
 - b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation
 - c. Mouth care performed when:
 - i) there is injury or disease of the face, mouth, head or neck
 - ii) in the presence of communicable disease
 - iii) the client is unconscious, OR
 - iv) oral suctioning is required
 - d. Dressing, including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary
 - e. Feeding
 - i) when suctioning is needed on a stand-by or other basis
 - ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study
 - iii) Syringe feeding, OR
 - iv) Feeding using apparatus
 - f. Exercise prescribed by a licensed medical professional including passive range of motion
 - g. Transferring a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed
 - h. Bowel care provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist
 - i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters

- j. Medical management required by a medical professional to monitor blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections
- k. Respiratory care:
 - i. Postural drainage
 - ii) Cupping
 - iii) Adjusting oxygen flow within established parameters
 - iv) Suctioning of mouth and nose
 - v) Nebulizers
 - vi) Ventilator and tracheostomy care
 - vii) Prescribed respiratory equipment

8.500.94.B PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES

Participant direction of HCBS-SLS waiver services is authorized pursuant to the provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293 and C.R.S. 25.5-6-1101, et seq. (2014).

- 1. Participants may choose to direct their own services through the Consumer Directed Attendant Support Services delivery OPTION SET FORTH at Section 8.510, et seq.
- 2. Services that may be participant-directed UNDER THIS OPTION are as follows:
 - i) Personal Care as defined at Section 10 CCR 2505-10 §8.500.94.A.10
 - ii) Homemaker as defined at Section 10 CCR 2505-10 §8.500.94.A.6
 - iii) Health Maintenance Activities as defined at Section 10 CCR 2505-10 §8.500.94.A.17
- 3. The case manager shall conduct the case management functions SET FORTH at section 8.510.14 et. seq.

8.500.95 SERVICE PLAN:

8.500.95.A The case management agency shall complete a service plan for each client enrolled in the HCBS Waiver in accordance with 10 CCR 2505-10, Section 8.400.

8.500.95.B The service plan shall:

- 1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver services or through other means,
- 2. Be in accordance with the Department's rules, policies and procedures, and
- 3. Include updates and revisions at least annually or when warranted by changes in the client's needs.

8.500.95.C The service plan shall document that the client has been offered a choice:

1. Between waiver services and institutional care,
2. Among waiver services, and
3. Among qualified providers.

8.500.96 WAITING LIST PROTOCOL

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

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

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

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

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

1. The date on which eligibility for developmental disabilities services in Colorado was originally determined; or
2. The fourteenth (14th) birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

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

1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered and the emergency cannot be resolved in another way. Emergencies are defined as follows:
 - a. Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode.
 - b. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.
 - c. Danger to Others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

- d. Danger to Self: a person's medical, psychiatric or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.
- e. The Legislature has appropriated funds specific to individuals or to a specific class of persons.
- f.. If an eligible individual is placed on a waiting list for SLS waiver services, a written notice, including information regarding the client appeals process, shall be sent to the individual and/or his/her legal guardian in accordance with the provisions of Section 8.057, *et seq.*

8.500.97 CLIENT RESPONSIBILITIES

8.500.97.A A client or the client's family or guardian is responsible for:

- 1. Providing accurate information regarding the client's ability to complete activities of daily living,
- 2. Assisting in promoting the client's independence,
- 3.
- 4. Cooperating in the determination of financial eligibility,
- 5. Notifying the case manager within thirty (30) days after:
 - a. Changes in the client's support system, medical condition and living situation including any hospitalizations, emergency room admissions,
 - b. Placement to a nursing home or intermediate care facility for the mentally retarded (ICF-MR),
 - c. The client has not received an HCBS waiver service during one (1) month
 - d. Changes in the client's care needs,
 - e. Problems with receiving HCBS-SLS waiver services, and
 - f. Changes that may affect Medicaid financial eligibility including prompt report of changes in income or assets.

8.500.98 PROVIDER REQUIREMENTS

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

- 1. Conform to all state established standards for the specific services they provide under HCBS-SLS,
- 2. Maintain program approval and certification from the Operating Agency,
- 3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,

4. Discontinue HCBS-SLS services to a client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.
5. Have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S., as amended,
6. When applicable, maintain the required licenses from the Colorado Department of Public Health And Environment, and
7. Maintain client records to substantiate claims for reimbursement according to Medicaid standards.

8.500.98.B HCBS-SLS providers shall comply with:

1. All applicable provisions of 27, 10.5, C.R.S. et seq, and the rules and regulations as set forth in 2 CCR 503-1, 16.100 et seq.,:
2. All federal program reviews and financial audits of the HCBS-SLS waiver services,
3. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,
- 4.
5. Requests from the county Departments of Social/Human Services to access records of clients receiving services held by case management agencies as required to determine and re-determine Medicaid eligibility;
6. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-SLS waiver, and
7. Requests by the case management agency to monitor service delivery through targeted case management activities.

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

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

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 et seq,
2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-SLS services,
3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider,

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper client notification,
 5. Emergency termination of any provider agreement shall be in accordance with procedures at 10 CCR 2505-10, section 8.050, and
- 8.500.99.B The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

8.500.100 ORGANIZED HEALTH CARE DELIVERY SYSTEM

- 8.500.100.A The Organized Health Care Delivery System (OHCDS) for the HCBS-SLS waiver is the Community Centered Board as designated by the Operating Agency in accordance with § 27-1010.5-103,.
- 8.500.100.B The OHCDS is the Medicaid provider of record for a client whose services are delivered through the OHCDS,
- 8.500.100.C The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS according to the current federally approved waiver.
- 8.500.100.D The OHCDS may contract or employ for delivery of HCBS Waiver services.
- 8.500.100.E The OCHDS shall:
1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS Waiver,
 2. Ensure that services are delivered according to the waiver definitions and as identified in the client's service plan,
 3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and
 4. Monitor the health and safety for HCBS clients receiving services from a subcontractor.
- 8.500.100.F The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:
1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,
 2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,
 3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients,
 4. Negotiate rates that are in accordance with the Operating Agency's established fee for service rate schedule and Operating Agency procedures,

- a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.
5. Collect and maintain the data used to develop provider rates and ensure data includes costs for services to address the client's needs, that are allowable activities within the HCBS service definition and that supports the established rate,
6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency or Centers for Medicare and Medicaid Services (CMS), and
7. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.500.101 PRIOR AUTHORIZATION REQUESTS

8.500.101.A Prior authorization requests (PAR) shall be in accordance with 10 C.C.R. 2505-10, Section 8.058.

8.500.101.B A prior authorization request shall be submitted to the Operating Agency through the Department's designated information management system.

8.500.101.C The case management agency shall comply with the policies and procedures for the PAR review process as set forth by the Department or the Operating Agency.

8.500.101.D The case management agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:

1. Consistent with the client's documented medical condition and functional capacity as indicated in the functional needs assessment,
2. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved waiver, and
3. Not duplicative of another authorized service, including services provided through:
 - a. Medicaid State plan benefits,
 - b. Third party resources,
 - c. Natural supports,
 - d. Charitable organizations, or
 - e. Other public assistance programs.
4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10 § 8.058.4.

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8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

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

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations and vehicle modifications.

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

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

8.500.102.E Each SPAL is associated with six support levels determined by an algorithm which analyzes a client's level of service need as determined by the SIS assessment and additional factors including exceptional medical and behavioral support needs and identification as a community safety risk.

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

8.500.102 G HEALTH MAINTENANCE ACTIVITIES AVAILABLE UNDER CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) IS NOT SUBJECT TO THE SERVICE PLAN AUTHORIZATION LIMIT

8.500.103 RETROSPECTIVE REVIEW PROCESS

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

1. Identified in the service plan are based on the client's identified needs as stated in the functional needs assessment,
2. Have been requested and approved prior to the delivery of services,
3. Provided to a client are in accordance with the service plan, and
4. Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

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

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

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

8.500.104 PROVIDER REIMBURSEMENT

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

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

1. Services are provided by a qualified provider as specified in the federally approved HCBS-SLS waiver,
2. Services have been prior authorized,
3. Services are delivered in accordance with the frequency, amount, scope and duration of the service as identified in the client's service plan, and
4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

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

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

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

8.500.104.F Except where otherwise noted, payment is based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin accessed through the Department's fiscal agent's web site.

8.500.105 INDIVIDUAL RIGHTS

8.500.105.A The rights of a client in the HCBS-SLS Waiver shall be in accordance with Sections 27-10.5-112 through 131, C.R.S.

8.500.106 APPEAL RIGHTS

8.500.106.A The CCB shall provide the long term care notice of action form to applicants and clients within ten (10) business days regarding their appeal rights in accordance with 10 CCR 2505-10, Section 8.057 *et seq.* When:

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

2. The applicant is found eligible or ineligible for LTC services,
 3. The applicant is determined eligible or ineligible for placement on a waitlist for Medicaid LTC services,
 4. An adverse action occurs that affects the client's waiver enrollment status,
 5. An adverse action occurs that affects the provision of the client's waiver services, or
 6. The applicant or client requests such information.
- 8.500.106.B The CCB shall represent their decision at the office of administrative courts as described in 10 CCR 2505-10, Section 8.057 *et seq* when CCB has made a denial or adverse action against a client.
- 8.500.106.C The CCB shall notify all providers in the client's service plan within ten (10) business day of the adverse action.
- 8.500.106.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.
- 8.500.106.E The applicant or client shall be informed of an adverse action if the client is determined ineligible as set forth in client eligibility and the following:
1. The client cannot be served safely within the cost containment as identified in the HCBS-SLS Waiver,
 2. The client is placed in an institution for treatment with a duration that continues for more than thirty (30) days,
 3. The client is detained or resides in a correctional facility, or
 4. The client enters an institute for mental health with a duration that continues for more than thirty (30) days.
- 8.500.106.F The client shall be notified, pursuant to 10 CCR 2505-10, Section 8.057.2.A, when the following results in an adverse action that does not relate to HCBS-SLS waiver client eligibility requirements:
1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the functional needs assessment,
 2. A waiver service is terminated or denied because is not available through the current federally approved waiver,
 3. A service plan or waiver service exceeds the limits as set forth in the in the federally approved waiver,
 4. The client or client representative has failed to schedule an appointment for the functional needs assessment, service plan, or six (6) month visit with the case manager two (2) times in a thirty (30) day consecutive period,
 5. The client or client representative has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,

6. The client enrolls in a different long term care program, or
 7. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.
 - a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual 9 CCR 2503-1, Section 3.140.2,, shall not be terminated unless one or more of the other client eligibility criteria are no longer met.
 8. The client voluntarily withdraws from the waiver. The client shall be terminated from the waiver effective upon the day after the date on which the client's request is documented.
- 8.500.106.G The CCB shall not send the LTC notice of action form when the basis for termination is death of the client, but shall document the event in the client record. The date of action shall be the day after the date of death.

8.500.107 QUALITY ASSURANCE

- 8.500.107.A. The monitoring of services provided under the HCBS-SLS waiver and the health and well-being of clients shall be the responsibility of the Operating Agency, under the oversight of the Department.
- 8.500.107.B. The Operating Agency shall conduct on-site surveys or cause to have on-site surveys to be done in accordance with guidelines established by the Department or the Operating Agency. The survey shall include a review of applicable Operating Agency rules and regulations and standards for HCBS-SLS.
- 8.500.107.C The Operating Agency, shall ensure that the case management agency fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.
- 8.500.107.D The Operating Agency, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials which pertain to the operation and service delivery of the SLS waiver program.
- 8.500.107.E The Operating Agency shall recommend to the Department the suspension of payment denial or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.
- 8.500.107.F After receiving the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action.

8.500.108 CLIENT PAYMENT-POST ELIGIBILITY TREATMENT OF INCOME

- 8.500.108.A A client who is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard at 10 CCR 2505-10 §8.1100.7, is required to pay a portion of the client's income toward the cost of the client's HCBS-SLS services after allowable income deductions.
- 8.500.108.B This post eligibility treatment of income (PETI) assessment shall:

1. Be calculated by the case management agency during the client's initial assessment and continued stay review for HCBS-SLS services.
2. Be recomputed, as often as needed, by the case management agency in order to ensure the client's continued eligibility for the HCBS-SLS waiver

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

1. A maintenance allowance equal to three hundred percent (300%) of the current SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty five dollars (\$245) per month; and
2. For a client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and
3. For a client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate AFDC grant level; and
4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:
 - a. Health insurance premiums (other than Medicare), deductibles, or coinsurance charges, (including Medicaid copayments)
 - b. Necessary medical or remedial care recognized under state law but not covered under the Medicaid State Plan.

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

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

8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (CES)

8.503 DEFINITIONS

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

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

APPLICANT means an individual who is seeking a Long Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

AUTHORIZED REPRESENTATIVE (AR) means an individual designated by the client, parent or legal guardian of a minor, if appropriate, who has the judgment and ability to direct CDASS on the client's behalf and meets the qualifications as defined at 10 CCR 2505-10 Sections 8.510.6 and 8.510.7.

CLIENT means an individual who has met Long Term client representative may be (A) a legal representative including but not limited to a court appointed guardian, a parent of a minor child, or a spouse, or (B) an individual, family member or friend selected by the parent or guardian of the client to speak for or act on the clients' behalf.

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which, when designated pursuant to Section 27-10.5-101, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-101, C.R.S. et seq., and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.

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

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

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

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

DEVELOPMENTAL DELAY means a child who is:

Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:

Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age,

Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development,

Has an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or

Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a Community Centered Board.

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include Cerebral palsy, Epilepsy, Autism or other neurological conditions when such condition result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, unless otherwise specifically stated, the federal definition "Developmental Disability" found in 42 U.S.C. Section 6000 *et seq.*

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

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

"Substantial intellectual deficits" 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.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services- Children's Extensive Support (HCBS-CES) to persons with developmental delays or disabilities within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of the Medicaid State Plan for a Medicaid eligible client up to 21 years of age.

FAMILY means a relationship as it pertains to the client and is defined as:

A mother, father, brother, sister or any combination,

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

An adoptive parent,

One or more individuals to whom legal custody of a person with a developmental disability has been given by a court,

A spouse or,

The client's child.

FISCAL MANAGEMENT SERVICE ORGANIZATION means the entity contracted with the Department as the employer of record for attendants, to provide personnel management services, fiscal management services and skills training to a parent or guardian or authorized representative of a client receiving CDASS.

FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for Long Term Care services as determined by the Department

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long Term Care instrument and medical verification on the Professional Medical Information Page to determine if the applicant or client meets the institutional Level Of Care (LOC).

GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not a guardian ad litem.

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR).

INSTITUTION means a hospital, nursing facility, facility or ICF/MR for which the Department makes Medicaid payments under the state plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR) means a publicly or privately operated facility that provides health and habilitation services to a client with developmental disabilities or related conditions.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the client's legal representative.

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

LICENSED MEDICAL PROFESSIONAL means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses; physician, physician assistant and nurse governed by the Colorado Medical License Act.

LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), or Home and Community Based Services (HCBS), Long Term Home Health Services, the program of All-Inclusive Care for the Elderly, Swing Bed and Hospital Back Up program (HBU).

MEDICAID ELIGIBLE means the applicant or client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination.

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

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

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

OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services-for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDs) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the HCBS-DD, HCBS-SLS and HCBS-CES waivers.

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

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional Level Of Care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1, Section 16.200 *et seq.*, that has received program approval to provide HCBS-CES waiver services.

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

RETROSPECTIVE REVIEW means the Department or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service.

SERVICE PLAN means the written document that specifies identified and needed services, regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department and the Operating Agency's rules set forth in 10 CCR 2505-10, Section 8.400.

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

TARGETED CASE MANAGEMENT SERVICES (TCM) means a Medicaid State Plan benefit for a target population which includes: facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources including but not limited to medical, social, educational and other resources to ensure non-duplication of HCBS waiver services and the monitoring of the effective and efficient provision of HCBS waiver services across multiple funding sources.

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

UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the Department of Health Care Policy and Financing to review the HCBS-CES waiver applications for determination of eligibility based on the additional targeting criteria.

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

8.503.10 HCBS-CES WAIVER ADMINISTRATION

8.503.10.A This section hereby incorporates the terms and provisions of the federally-approved Home and Community Based Services-Children's Extensive Support (HCBS-CES) waiver CO.4180.R03.00. To the extent that the terms of that federally-approved waiver are inconsistent with the provisions of this section, the waiver will control

8.503.10.B HCBS-CES waiver for clients ages birth through seventeen years of age with developmental delays or disabilities is administered through the designated Operating Agency.

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

8.503.10.D. In the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the rules and regulations of the Department shall control.

8.503.10.E. HCBS-CES waiver services are available only to address needs identified in the Functional Needs Assessment and authorized in the service plan and when the service or support is not available through the Medicaid State Plan, EPSDT, natural supports, or third party payment sources.

8.503.10.F. HCBS-CES waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,
2. Shall be subject to annual appropriations by the Colorado general assembly,
3. Shall limit the utilization of the HCBS-CES waiver based on the federally approved capacity, cost containment, the maximum costs and the total appropriations, and,
4. May limit the enrollment when utilization of the HCBS-CES waiver program is projected to exceed the spending authority.

8.503.20 GENERAL PROVISIONS

8.503.20.A THE FOLLOWING PROVISIONS SHALL APPLY TO THE HCBS-CES WAIVER.

1. HCBS-CES waiver services are provided as an alternative to ICF/MR services for an eligible client to assist the family to support the client in the home and community.

2. HCBS-CES waiver is waived from the requirements of Section 1902(a) (10) (b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the state of Colorado.
3. A client enrolled in the HCBS-CES waiver shall be eligible for all other Medicaid services for which the client qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-CES waiver. Services received through the HCBS-CES waiver may not duplicate services available through the Medicaid State Plan.

8.503.30 CLIENT ELIGIBILITY

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

1. Is unmarried and less than eighteen years of age,
2. Be determined to have a developmental disability which includes developmental delay if under five (5) years of age,
3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and cost containment limits of the HCBS-CES waiver,
4. Meet ICF/MR level of care as determined by the Functional Needs Assessment,
5. Meet the Medicaid financial determination for LTC eligibility as specified at 10 CCR 2505-10, Section 8.100 *et seq.* and,
6. Reside in an eligible HCBS-CES waiver setting as defined as the following:
 - a.) With biological, adoptive parent(s), or legal guardian,
 - b.) In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement that must be approved by the HCBS-CES waiver administrator:
 - i.) The case manager will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or supports requested during the time the client is not residing in the family home.
7. Be determined to meet the Federal Social Security Administration's definition of disability,
8. Be determined by the Utilization Review Contractor (URC) to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:
 - a.) The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

- i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six months,
 - ii.) A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six months, or
 - iii. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.
- b). The above conditions shall be evidenced by third party statement or data that is corroborated by written evidence that:
 - i) The individual's behavior or medical needs have been demonstrated, or
 - ii.) In the instance of an annual reassessment, that in the absence of the existing interventions or preventions provided through the HCBS-CES waiver that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criteria listed above.
- c Examples of acceptable evidence shall not be older than six months and shall include but not be limited to any of the following:
 - i.) Medical records,
 - ii) Professional evaluations and assessments,
 - iii.) Insurance claims,
 - iv) Behavior pharmacology clinic reports,
 - v.) Police reports,
 - vi) Social Services reports, or
 - vii.) Observation by a third party on a regular basis.

8.503.30.B The client shall maintain eligibility by meeting the HCBS-CES waiver eligibility as set forth in 10 CCR 2505-10, Section 8.503 and the following:

1. Receives at least one (1) HCBS-CES waiver service each calendar month,
2. Is not simultaneously enrolled in any other HCBS waiver, and
3. Is not residing in a hospital, nursing facility, ICF/MR, other institution or correctional facility.

8.503.40 HCBS-CES WAIVER SERVICES

8.503.40.A The following services are available through the HCBS-CES waiver within the specific limitations as set forth in the federally approved HCBS-CES waiver:

1. Adaptive Therapeutic Recreational Equipment and Fees are services which assist a client to recreate within the client's community. These services include recreational equipment that is adapted specific to the client's disability and not those items that a typical age peer would commonly need as a recreation item.
 - a. The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.
 - b. Adaptive recreational equipment may include adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a client with a developmental disability.
 - c. A pass for admission to recreation centers for the client only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.
 - d. Adaptive therapeutic recreation fees include those for water safety training.
 - e. The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:
 - i. Entrance fees for zoos,
 - i.) Museums,
 - ii.) Butterfly pavilion,
 - iii.) Movie, theater, concerts,
 - iv.) Professional and minor league sporting events,
 - v.) Outdoors play structures,
 - vi. Batteries for recreational items; and,
 - vii. Passes for family admission to recreation centers.
 - f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per service plan year.
2. Assistive Technology includes services, supports or devices that assist a client to increase maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:

- a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,
- b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,
- c. Training or technical assistance for the client, or where appropriate, the family members, guardians, care-givers, advocates, or authorized representatives of the client,
- d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-CES waiver, and
- e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency's procedures.
- f. Assistive Technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid State Plan or third party resource.
- g. Assistive Technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.
- h. When the expected cost is to exceed two thousand five hundred (2,500) dollars per device three estimates shall be obtained and maintained in the case record.
- i. Training and technical assistance shall be time limited, goal specific and outcome focused.
- j. The following items and services are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:
 - i. Purchase, training or maintenance of service animals,
 - ii. Computers,
 - iii. In home installed video monitoring equipment,
 - iv. Medication reminders,
 - v. Hearing aids,
 - vi. Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of games,
 - vii. training, or adaptation directly related to a school or home educational goal or curriculum; or
 - viii. items considered as typical toys for children.

- k. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures.:
 - i. The Operating Agency shall respond to exception requests within thirty (30) days of receipt.
- 3. Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.
 - a. Behavioral Services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.
 - b. A client with a co-occurring diagnosis of developmental disabilities and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.
 - c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.
 - d. Behavioral Services include:
 - i. Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.
 - a) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service must be established.
 - ii. Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.
 - 1) Behavioral plan assessment services are limited to forty (40) units and one assessment per service plan year. One unit is equal to fifteen (15) minutes of service.
 - iii. Individual and group counseling services include psychotherapeutic or psychoeducational intervention that:
 - 1.) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

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- 2.) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.
 - iv. Behavioral Line Services include direct implementation of the behavioral plan under the supervision and oversight of a behavioral consultant, for intervention to address social or emotional issues or with an identified challenging behavior that puts the individual's health and safety or the safety of others at risk.
 - 4. Community Connector Services are intended to provide assistance to the client to enable the client to integrate into the client's residential community and access naturally occurring resources. Community connector services shall:
 - a. Support the abilities and skills necessary to enable the client to access typical activities and functions of community life such as those chosen by the general population.
 - b. Utilize the community as a learning environment to assist the client to build relationships and natural supports in the client's residential community.
 - c. Be provided to a single client in a variety of settings in which clients interact with individuals without disabilities, and
 - d. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.
 - 5. Home Accessibility Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include:
 - a. The installation of ramps,
 - b. Widening or modification of doorways,
 - c. Modification of bathroom facilities to allow accessibility, and assist with needs in activities of daily living.
 - d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment or supplies that are necessary for the health and safety of the client, and
 - e. Safety enhancing supports such as basic fences or basic door and window alarms;
 - f. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:
 - i. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,

- ii.) Carpeting,
 - iii.) Roof repair,
 - iv.) Central air conditioning,
 - v.) Air duct cleaning,
 - vi.) Whole house humidifiers,
 - vii.) Whole house air purifiers,
 - viii.) Installation and repair of driveways and sidewalks,
 - viii.) Monthly or ongoing home security monitoring fees,
 - ix.) Home furnishings of any type,
 - x.) Adaptations to rental units when the adaptation is not portable and cannot move with the renter, and
 - xi.) Luxury upgrades.
 - g. 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.
 - h. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agency procedures.
 - i. All devices and adaptations shall be provided in accordance with applicable state or local building codes and applicable standards of manufacturing, design and installation. Medicaid State Plan, EPSDT or third party resources shall be utilized prior to authorization of HCBS-CES waiver services.
 - j. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with Operating Agency procedure.
6. Homemaker Services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of Homemaker Services:
- a. Basic Homemaker Services includes cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.

- i. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task.
 - ii. Lawn care, snow removal, air duct cleaning and animal care are specifically excluded under HCBS-CES waiver and shall not be reimbursed.
 - b. Enhanced Homemaker Services include Basic Homemaker Services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning.
 - i. Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.
 - ii. The provider shall be physically present to provide step by step verbal or physical instructions throughout the entire task:
 - 1) When such support is incidental to the habilitative services being provided,
 - 2) To increase independence of the client,
 - c. Incidental Basic Homemaker Service may be provided in combination with Enhanced Homemaker Services; however, the primary intent must be to provide habilitative services to increase independence of the client.
 - d. Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.
- 7. Parent Education provides unique opportunities for parents or other care givers to learn how to support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. Parent Education includes:
 - a. Consultation and direct service costs for training parents and other care givers in techniques to assist in caring for the client's needs, including sign language training,
 - b. Special resource materials,
 - c. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the client's disability,
 - d. Cost of membership to parent support or information organizations and publications designed for parents of children with disabilities.
 - e. The maximum service limit for parent education is one thousand (1,000) units per service plan year.

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- f. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:
 - i) Transportation,
 - ii) Lodging,
 - iii). Food, or
 - iv). Membership to any political organizations or any organization involved in lobby activities.
 - 8. Personal Care is assistance to enable a client to accomplish tasks that the client may complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task.
 - a. Personal care services include assistance with basic self care tasks that include performing hygiene activities, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.
 - b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required it shall be provided by the HCBS-CES waiver only to the extent the Medicaid State Plan or third party resource does not cover the service.
 - c. If the annual Functional Needs Assessment identifies a possible need for skilled care then the client shall obtain a home health assessment.
 - 9. Professional Services are provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Professional services include:
 - a. Hippotherapy: includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.
 - b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.
 - c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes WATSU.
 - d. Professional services can be reimbursed only when:
 - i). The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,
 - ii). The intervention is related to an identified medical or behavioral need; and
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- iii). The Medicaid state plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.
 - iv). The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:
 - 1) Acupuncture,
 - 2) Chiropractic care,
 - 3) Fitness training (personal trainer),
 - 4) Equine therapy,
 - 5) Art therapy,
 - 6) Warm water therapy,
 - 7) Therapeutic riding,
 - 8) Experimental treatments or therapies, and
 - 9) Yoga.
10. Respite is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.
- a. Respite may be provided:
 - i.) In the client's home, private residence,
 - ii.) The private residence of a respite care provider, or
 - iii.) In the community.
 - b. Respite is to be provided in an age appropriate manner.
 - i.) The eligible client age twelve (12) or older may receive respite during the time the care-giver works because same age typical peers do not need ongoing supervision at that age and the need for the respite is based on the client's disability.
 - ii.) A client eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children.
 - c. When the cost of care during the time the parents works is more for an eligible client, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care.

- d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible client when supervision is needed so the primary caretaker can take the client to receive a state plan benefit or a HCBS-CES waiver service.
- e. Respite shall be provided according to an individual or group rates as defined below:
 - i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.
 - ii) Individual day: the client receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty four (24)-hour period. A full day is ten (10) hours or greater within a twenty four (24)- hour period.
 - iii) Overnight group: the client receives respite in a setting which is defined as a facility that offers twenty four (24)-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty four (24)-hour period shall not exceed the respite daily rate.
 - iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a twenty four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:
 - 1) Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling.
- f. Federal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1 Section 16.221 by the state that is not a private residence.
- g. The total amount of respite provided in one service plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The Operating Agency may approve a higher amount based on a need due to the client's age, disability or unique family circumstances.
- h. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or services not covered by the HCBS-CES waiver.
- i. Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.
- j. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a client. Therefore, additional respite units beyond the service limit will not be approved for clients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.

11. Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized Medical Equipment and Supplies include:
 - a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;
 - b. Specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing;
 - c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-CES waiver.
 - d. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:
 - i) Items that are not of direct medical or remedial benefit to the client vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.
12. Vehicle Modifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation, to accommodate the special needs of the client, are necessary to enable the client to integrate more fully into the community and to ensure the health, and safety of the client.
 - a. Upkeep and maintenance of the modifications are allowable services.
 - b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include:
 - i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client,
 - ii) Purchase or lease of a vehicle, and
 - iii) Typical and regularly scheduled upkeep and maintenance of a vehicle
 - c. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no unnecessary duplication.

13. Vision service
 - a. Vision therapy is a sequence of activities individually prescribed and monitored by a Doctor of Optometry or Ophthalmology to develop efficient visual skills and processing. It is based on the results of standardized tests, the needs of the client and the client's signs and symptoms. It is used to treat eye movement disorders, inefficient eye teaming, misalignment of the eyes, poorly developed vision, focusing problems and visual information processing disorders to enhance visual skills and performing visual tasks.
 - b. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:
 - i) Eye glasses as a benefit under Medicaid State Plan,
 - ii) Contacts, or
 - iii) General vision checks
 - c. Vision therapy is provided only when the services are not available through the Medicaid State Plan or EPSDT and due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, Section 8.208.1 or available through a third party resource.

8.503.50 SERVICE PLAN

8.503.50.A The case management agency shall complete a service plan for each client enrolled in the HCBS-CES waiver in accordance with 10 CCR 2505-10 Section 8.400.

1. The service plan shall:
 - a. Address the client's assessed needs and personal goals, including health and safety risk factors either by HCBS-CES waiver services or any other means,
 - b. Be in accordance with the Department's and the Operating Agency's rules, policies and procedures,
 - c. Be entered and verified in the Department prescribed system within ten (10) business days,
 - d. Describe the types of services to be provided, the amount, frequency and duration of each service and the type of provider for each service,
 - e. Include a statement of agreement, and.
 - f. Be updated or revised at least annually or when warranted by changes in the HCBS-CES waiver client's needs,
2. The Service Plan shall document that the client has been offered a choice:
 - a. Between HCBS-CES waiver services and institutional care,
 - b. Among HCBS-CES waiver services, and
 - c. Among qualified providers.

8.503.60 WAITLIST PROTOCOL

8.503.60.A When the HCBS-CES waiver reaches capacity for enrollment, a client determined eligible for HCBS-CES waiver benefits shall be placed on a statewide wait list in accordance with these rules and the Operating Agency's procedures.

1. The Community Centered Board shall determine if an applicant has developmental delay if under age five (5), or developmental disability if over age five (5) prior to submitting the HCBS-CES waiver application to the utilization review contractor. Only a client who is determined to have a developmental delay or developmental disability may apply for HCBS-CES waiver.
2. In the event a client who has been determined to have a developmental delay is placed on the wait list prior to age five (5), and that client turns five (5) while on the HCBS-CES waiver wait list, a determination of developmental disability must be completed in order for the client to remain on the wait list.
3. The case management agency shall complete the Functional Needs Assessment, as defined in Department rules, to determine the client's Level Of Care.
4. The case management agency shall complete the HCBS-CES waiver application with the participation of the family. The completed application and a copy of the Functional Needs Assessment that determines the client meets the ICF/MR level of care shall be submitted to the Utilization Review Contractor within fourteen (14) calendar days of parent signature.
5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the utilization review contractor.
6. The utilization review contractor shall review the HCBS-CES waiver application. In the event the utilization review contractor needs additional information, the case management agency shall respond within two (2) business days of request.
7. Any client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide wait list in the order in which the utilization review contractor received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the client's appeal rights in accordance with 10 CCR 2505-10, Section 8.057.
8. The case management agency will create or update the consumer record to reflect the client is waiting for the HCBS-CES waiver with the wait list date as determined by the utilization review contractor.

8.503.70 ENROLLMENT

8.503.70.A When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.

1. The case management agency shall complete the HCBS-CES waiver application and the Functional Needs Assessment in the family home with the participation of the family. The completed application and a copy of the Functional Needs Assessment shall be submitted to the Utilization Review Contractor within thirty (30) days of the authorized initial enrollment date.

- a. If it has been less than six (6) months since the review to determine wait list eligibility by the Utilization Review Contractor and there has been no change in the client's condition, the case management agency shall complete the Functional Needs Assessment and the parent may submit a letter to the case management agency in lieu of the HCBS-CES waiver application stating there has been no change.
 - b. If there has been any change in the client's condition the case management agency shall complete a Functional Needs Assessment and the HCBS-CES waiver application which shall be submitted to the Utilization Review Contractor.
3. Services and supports shall be implemented pursuant to the service plan within 90 days of the parent or guardian signature.
4. All continued stay review enrollments shall be completed and submitted to the utilization review contractor at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

8.503.80 CLIENT RESPONSIBILITIES

8.503.80.A The parent or legal guardian of a client is responsible to assist in the enrollment of the client and cooperate in the provision of services. Failure to do so shall result in the client's termination from the HCBS-CES waiver. The parent or legal guardian shall:

1. Provide accurate information regarding the client's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions.
2. Cooperate with providers and case management agency requirements for the HCBS-CES waiver enrollment process, continued stay review process and provision of services;
3. Cooperate with the local Department of Human Services in the determination of financial eligibility;
4. Complete the HCBS-CES waiver application with fifteen calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a continued stay review, at least thirty (30) days prior to the end of the current certification period;
5. Complete the Service Plan within thirty calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the Utilization Review Contractor;
6. Notify the case manager within thirty (30) days after changes:
 - a. In the client's support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF/MR placements;
 - b. That may affect Medicaid financial eligibility such as prompt report of changes in income or resources;
 - c. When the client has not received an HCBS-CES waiver service for one calendar month;
 - d. In the client's care needs; and,

- e. In the receipt of any HCBS-CES waiver services.

8.503.90 PROVIDER REQUIREMENTS

8.503.90.A A private for profit or not for profit agency or government agency shall ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver and shall:

1. Conform to all state established standards for the specific services they provide under HCBS-CES waiver,
2. Maintain program approval and certification from the Operating Agency,
3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,
4. Discontinue HCBS-CES waiver services to a client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide HCBS-CES waiver services,
5. Have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S., as amended,
6. When applicable, maintain the required licenses and certifications from the Colorado Department of Public Health and Environment, and
7. Maintain client records to substantiate claims for reimbursement according to Medicaid standards.

8.503.90.B HCBS-CES waiver service providers shall comply with:

1. All applicable provisions of 27, Article 10.5, C.R.S., et seq. and all rules and regulations as set forth in 2 CCR 503-1, Section 16.100 *et seq.*,
2. All federal or state program reviews or financial audit of HCBS-CES waiver services,
3. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program monitoring or financial and program audits,
4. Requests from the County Departments of Human Services to access records of clients and to provide necessary client information to determine and re-determine Medicaid financial eligibility,
5. Requests by the Department of the Operating Agency to collect, review and maintain individual or agency information on the HCBS-CES waiver, and
6. Requests by the case management agency to monitor service delivery through targeted case management activities.

8.503.100 TERMINATION OR DENIAL OF HCBS-CES MEDICAID PROVIDER AGREEMENTS

8.503.100.A The Department may deny or terminate an HCBS-CES waiver Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq.*
2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-CES waiver services.
3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.
4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior client notification.
5. The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.
6. Emergency termination of any provider agreement shall be in accordance with procedures at 10 CCR 2505-10, Section 8.050.

8.503.110 ORGANIZED HEALTH CARE DELIVERY SYSTEM

8.503.110.A The Organized Health Care Delivery System (OHCDS) for HCBS-CES waiver is the Community Centered board as designated by the Operating Agency in accordance with Section 27-10.5-103, C.R.S.

1. The OHCDS is the Medicaid provider of record for a client whose services are delivered through the OHCDS.
2. The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS-CES waiver services according to the current federally approved waiver.
3. The OHCDS may contract or employ for delivery of HCBS-CES waiver services.
4. The OCHDS shall:
 - a. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver,
 - b. Ensure that services are delivered according to the HCBS-CES waiver definitions and as identified in the client's service plan,
 - c. Ensure the contractor maintains sufficient documentation to support the claims submitted, and
 - d. Monitor the health and safety of HCBS-CES waiver clients receiving services from a subcontractor.
5. The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

- a. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,
- b. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,
- c. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients
- d. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and Operating Agency procedures,
 - i.) Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.
- e. Collect and maintain the data used to develop provider rates and ensure data includes costs for the services to address the client's needs, that are allowable activities within the HCBS-CES waiver service definition and that supports the established rate, and
- f. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency and Centers for Medicare and Medicaid Services (CMS).
- g. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.503.120 PRIOR AUTHORIZATION REQUESTS

8.503.120.A Prior Authorization Requests (PAR) shall be in accordance with 10 CCR 2505-10, Section 8.058.

- 1. A Prior Authorization Request shall be submitted to the Operating Agency through the Department's designated information management system.
- 2. The case management agency shall comply with the policies and procedures for the PAR review process as set forth by the Department and the Operating Agency.
- 3. The case management agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:
 - a. Consistent with the client's documented medical condition and functional capacity as indicated in the Functional Needs Assessment,
 - b. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved HCBS-CES waiver, and
 - c. Not duplicative of another authorized service, including services provided through:
 - i.) Medicaid State Plan benefits,

- ii.) Third party resources,
 - iii.) Natural supports,
 - iv.) Charitable organizations, or
 - v.) Other public assistance programs.
4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10, Section 8.058.4.

8.503.130 RETROSPECTIVE REVIEW PROCESS

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

- 1. Identified in the service plan is based on the client's identified needs as stated in the Functional Needs Assessment,
- 2. Have been requested and approved prior to the delivery of services,
- 3. Provided to a client are in accordance with the service plan, and
- 4. Provided are within the specified HCBS service definition in the federally approved HCBS-CES waiver.

8.503.130.B The case management agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency when areas of non-compliance are identified in the retrospective review.

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

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

8.503.140 PROVIDER REIMBURSEMENT

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

- 1. Provider claims for reimbursement shall be made only when the following conditions are met:
 - a. Services are provided by a qualified provider as specified in the federally approved HCBS-CES waiver,
 - b. Services have been prior authorized,
 - c. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the client's service plan, and

- d. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.
2. Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.
3. When the review identifies areas of non compliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.
4. When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.503.150 CLIENT RIGHTS

8.503.150.A Client rights should be in accordance with Sections 27-10.5-112- through 131 C.R.S.

8.503.160 APPEAL RIGHTS

8.503.160.A The CCB shall provide the Long Term Care notice of action form (LTC 803) to the applicant and client's parent or legal guardian within ten (10) business day regarding the client's appeal rights in accordance with 10 CCR 2505-10, Section 8.057 *et seq.* when:

1. The Applicant is determined not to have a developmental delay or developmental disability,
2. The Applicant is determined eligible or ineligible for Medicaid LTC services,
3. The Applicant is determined eligible or ineligible for placement on a waitlist for Medicaid LTC services,
4. An Adverse Action occurs that affects the client's HCBS-CES waiver enrollment status through termination or suspension,
5. An Adverse Action occurs that affects the provision of HCBS-CES waiver services or,
6. The Applicant or client requests such information.

8.503.160.B The CCB shall represent their decision at the Office of Administrative Courts as described in 10 CCR 2505-10, Section 8.057 *et seq.* when the CCB has made a denial or adverse action against a client.

8.503.160.C The CCB shall notify all providers in the client's service plan within one (1) working day of the adverse action.

8.503.160.D The CCB shall notify the County Department of Human Services income maintenance technician within one (1) business day of an Adverse Action that affects Medicaid financial eligibility.

8.503.160.E The applicant's parent or legal guardian shall be informed of an adverse action if the applicant or client is determined ineligible as set forth in client eligibility and the following:

1. The applicant, parent or legal guardian fails to submit the Medicaid financial application for LTC to the financial eligibility site within thirty (30) days of LTC referral,
2. A client, parent or legal guardian fails to submit financial information for re-determination for LTC to the financial eligibility site within the required re-determination timeframe,
3. The County Income Maintenance Technician has determined the client no longer meets financial eligibility criteria as set forth in 10 CCR 2505-10, Section 8.100,
4. The client cannot be served safely within the cost containment as identified in the HCBS-CES waiver,
5. The client requires twenty four (24) hour supports provided through Medicaid state plan,
6. The resulting total cost of services provided to the client, including Targeted Case Management, home health and HCBS-CES waiver services, exceeds the cost containment as identified in the HCBS-CES waiver,
7. The client enters an institution for treatment with duration that continues for more than thirty (30) days,
8. The client is detained or resides in a correctional facility, and
9. The client enters an institute for mental illness with a duration that continues for more than thirty (30) days.

8.503.160.F The client and parent or legal guardian shall be notified, pursuant to 10 CCR 2505-10, Section 8.057, when the following results in an adverse action that does not relate to HCBS-CES waiver client eligibility requirements:

1. A HCBS-CES waiver service is reduced, terminated or denied because it is not a demonstrated need in the Functional Needs Assessment or because it is not available through the current federally approved HCBS-CES waiver,
2. A service plan for HCBS-CES waiver services exceed the limits as set forth in the in the federally approved HCBS-CES waiver,
3. The parent or legal guardian has failed to schedule an appointment for the Functional Needs Assessment of the client, service plan, or 6 month visit two (2) times in a thirty (30) day consecutive period,
4. The parent or legal guardian has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,
5. The parent or legal guardian failed to complete the HCBS-CES waiver application within fifteen (15) calendar days of the authorized enrollment date as determined by the Operating Agency,
6. The parent or legal guardian fails to complete the service plan within thirty (30) calendar days of the authorized enrollment date as determined by the Operating Agency,

7. The parent or legal guardian refuses to use the home care allowance to pay for services, or uses the home care allowance payment for services not identified in the service agreement,
8. The parent or legal guardian refuses to sign the statement of agreement or other forms as required to receive services,
9. The client enrolls in a different long term care program,
10. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.
 - a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual 9 CCR 2503-1, Section 3.140.2, residence, shall not be discontinued unless one or more of the other client eligibility criteria are no longer met.
11. The parent or legal guardian voluntarily withdraws the client from HCBS-CES waiver. The client shall be discontinued from the program effective upon the day after the date on which the parent or legal guardian request is documented.
12. The CCB shall not send the LTC notice of action form when the basis for discontinuation is death of the client, but shall document the event in the client record and the date of action shall be the day after the date of death.

8.503.170 QUALITY ASSURANCE

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

1. The Operating Agency shall conduct reviews of each agency providing HCBS-CES waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department or Operating Agency and Department. The review shall apply rules and standards developed for programs serving clients with developmental disabilities.
2. The Operating Agency shall maintain or cause to be maintained for three (3) years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-CES waiver or the delivery of services under the HCBS-CES waiver. The Department shall have access to these records at any reasonable time.
3. The Operating Agency shall recommend to the Department the suspension of payment, the denial or termination of the Medicaid provider agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.
4. After having received the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action within a reasonable timeframe agreed upon by the Department and the Operating Agency.

8.503.210 POST ELIGIBILITY TREATMENT OF INCOME (PETI)

For individuals who are determined to be Medicaid eligible for the CES waiver through the application of the 300% income standard at 8.110.8, the case manager shall allow an amount equal to the 300% standard as the personal maintenance allowance (no other deductions are necessary). The PETI assessment form shall be completed monthly by the case management agency to ensure that the individual's income does not exceed the maximum allowed for continued eligibility.

8.504 HOME AND COMMUNITY BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESS WAIVER

8.504.05 Legal Basis

The Home and Community Based Services for Children with Life Limiting Illness program (HCBS-CLLI) in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CLLI program is also authorized under state law at C.R.S. § 25.5-5-305 et seq. – as amended.

8.504.1 DEFINITIONS

- A. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved assessment tool to complete assessments.
- B. Bereavement Counseling means counseling provided to the client and/or family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the client and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.
- C. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs.
- D. Continued Stay Review (CSR) means a reassessment by the Single Entry Point case manager to determine the client's continued eligibility and functional level of care.
- E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital.
- F. Curative Treatment means medical care or active treatment of a medical condition seeking to affect a cure.
- G. Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the client to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.
- H. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

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- I. Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood at age 19.
- J. Massage Therapy means the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.
- K. Palliative/Supportive Care is a specific program offered by a licensed health care facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care is specialized medical care for people with life limiting illnesses. This type of care is focused on providing clients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the client and the family. Palliative care is appropriate at any age (18 and under for this waiver) and at any stage in a life limiting illness and can be provided together with curative treatment. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of this waiver, Palliative Care includes Care Coordination and Pain and Symptom Management.
1. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a seamless system of care. Care Coordination does not include utilization management, that is review and authorization of service requests, level of care determinations, and waiver enrollment, provided by the case manager at the Single Entry Point.
 2. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the client's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.
- L. Prior Authorization Request (PAR) means the Department's prescribed form to authorize services.
- M. Professional Medical Information Page (PMIP) means the medical information signed by a licensed medical professional used as a component of the Assessment to determine the client's need for institutional care.
- N. Respite Care means services provided to an eligible client who is unable to care for himself/herself on a short term basis because of the absence or the need for relief of those persons normally providing care. Respite Care is provided in the client's residence and may be provided by different levels of providers depending upon the needs of the client.
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- O. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking or receiving services of his or her rights and responsibilities.
- P. Therapeutic Life Limiting Illness Support means grief/loss or anticipatory grief counseling that assist the client and family to decrease emotional suffering due to the client's health status, to decrease feelings of isolation or to cope with the client's life limiting diagnosis. Support is intended to help the child and family in the disease process. Support is provided to the client to decrease emotional suffering due to health status and develop coping skills. Support is provided to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending death of a child. Support is provided to the client and/or family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Support will include but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the family with community resources such as funding or transportation.
- Q. Utilization Review means approving or denying admission or continued stay in the waiver based on level of care needs, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures or settings.

8.504.2 BENEFITS

- 8.504.2.A. Home and Community Based Services under the Children with Life Limiting Illness Waiver (HCBS-CLLI) benefits shall be provided within Cost Containment.
- 8.504.2.B. Therapeutic Life Limiting Illness Support may be provided in individual or group setting.
1. Therapeutic Life Limiting Illness Support shall only be a benefit if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or by other means.
 2. Therapeutic Life Limiting Illness Support is limited to the client's assessed need up to a maximum of 98 hours per annual certification period.
- 8.504.2.C. Bereavement Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.
1. Bereavement Counseling is limited to the client's assessed need and is only billable one time.
 2. Bereavement Counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.
- 8.504.2.D. Expressive Therapy may be provided in an individual or group setting.
1. Expressive Therapy is limited to the client's assessed need up to a maximum of 39 hours per annual certification period.
- 8.504.2.E. Massage Therapy shall be provided in an individual setting.

1. Massage Therapy shall only be used for the treatment of conditions or symptoms related to the client's illness.
 2. Massage Therapy shall be limited to the client's assessed need up to a maximum of 24 hours per annual certification period.
- 8.504.2.F. Respite Care shall be provided in the home of an eligible client on a short term basis, not to exceed 30 days per annual certification as determined by the Department approved Assessment. Respite Care shall not be provided at the same time as state plan Home Health or Palliative/Supportive Care services.
1. Respite Care services include any of the following in any combination necessary according to the Support Planning services:
 - a. Skilled nursing services;
 - b. Home health aide services; or
 - c. Personal care services
- 8.504.2.G. Palliative/Supportive Care shall not require a nine month terminal prognosis for the client and includes:
1. Pain and Symptom Management; and
 2. Care Coordination
- 8.504.2.H. HCBS-CLLI clients are eligible for all other Medicaid state plan benefits, including Hospice and Home Health.

8.504.3 NON-BENEFIT

- 8.504.3.A. Case Management is not a benefit of the HCBS-CLLI waiver. The Single Entry Point (SEP) provides case management services as an administrative activity.

8.504.4 CLIENT ELIGIBILITY

- 8.504.4.A. An eligible client shall:
1. Be financially eligible.
 2. Be at risk of institutionalization into a hospital as determined by the SEP case manager using the Department approved assessment tool.
 3. Meet the target population criteria as follows:
 - a. Have a life-limiting diagnosis, as certified by a physician on the Department prescribed form, and
 - b. Have not yet reached 19 years of age.
- 8.504.4.B A client shall receive at least one HCBS-CLLI waiver benefit per month to maintain enrollment in the waiver.

1. A client who has not received at least one HCBS-CLLI waiver benefit during a month shall be discontinued from the waiver.
2. Case Management does not satisfy the requirement to receive at least one benefit per month on the HCBS-CLLI waiver.

8.504.5 WAIT LIST

8.504.5.A. The number of clients who may be served through the waiver at any one time during a year shall be limited by the federally approved HCBS-CLLI waiver document.

8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-CLLI waiver, who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a wait list maintained by the Department.

8.504.5.C. The SEP case manager shall ensure the applicant meets all criteria as set forth in Section 8.504.4.A prior to notifying the Department to place the applicant on the wait list.

8.504.5.D. The SEP case manager shall enter the client's Assessment and Professional Medical Information Page data in the Benefits Utilization System (BUS) and notify the Department by sending the client's enrollment information, utilizing the Department's approved form, to the program administrator.

8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish the order of an applicant's place on the wait list.

8.504.5.F. Within five working days of notification from the Department that an opening for the HCBS-CLLI waiver is available, the SEP case manager shall:

1. Reassess the applicant for functional level of care using the Department approved assessment tool if the date of the last Assessment is more than six months old.
2. Update the existing Department approved assessment tool data if the date is less than six months old.
3. Reassess for the target population criteria.
4. Notify the Department of the applicant's eligibility status.

8.504.6 PROVIDER ELIGIBILITY

8.504.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CLLI waiver, enter into an agreement with the Department. Providers must comply with the requirements of 10 CCR 2505-10, Section 8.130.

8.504.6.B. Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure regulations.

8.504.6.C. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

8.504.6.D. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall be one of the following:

1. Licensed Clinical Social Worker (LCSW)
2. Licensed Professional Counselor (LPC)
3. Licensed Social Worker (LSW)
4. Licensed Independent Social Worker (LISW)
5. Licensed Psychologist; or
6. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice agency.

8.504.6.E. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

1. Individuals providing Expressive Therapy delivering art or play therapy services shall meet the requirements for individuals providing Therapeutic Life Limiting Illness Support services and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent clients.
2. Individuals providing Expressive Therapy delivering music therapy services shall hold a Bachelor's, Master's or Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists, and have at least one year of experience in the provision of music therapy to pediatric/adolescent clients.

8.504.6.F. Massage Therapy providers shall have an approved registration and be in good standing with the Colorado Office of Massage Therapy Registration.

8.504.6.G. Individuals providing Palliative/Supportive Care services shall be employed by or working under a formal contract with a qualified Medicaid hospice or home health agency.

8.504.6.H. Individuals providing Respite services shall be employed by a qualified Medicaid home health, hospice or personal care agency.

8.504.7 PROVIDER RESPONSIBILITIES

8.504.7.A. HCBS-CLLI providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining and terminating employees.
2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section 19-3-307 C.R.S. (2016).

8.504.7.B. HCBS-CLLI providers shall:

1. Ensure a client is not discontinued or refused services unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.
2. Ensure client records and documentation of services are made available at the request of the case manager.
3. Ensure that adequate records are maintained.

- a. Client records shall contain:
 - i. Name, address, phone number and other identifying information for the client and the client's parent(s) and/or legal guardian(s).
 - ii. Name, address and phone number of the SEP and the Case Manager.
 - iii. Name, address and phone number of the client's primary physician.
 - iv. Special health needs or conditions of the client.
 - v. Documentation of the specific services provided which includes:
 - 1. Name of individual provider.
 - 2. The location for the delivery of services.
 - 3. Units of service.
 - 4. The date, month and year of services and, if applicable, the beginning and ending time of day.
 - 5. Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.
 - 6. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.02.
 - 7. Documentation of communication with the client's SEP case manager.
 - 8. Documentation of communication/coordination with other providers.
- b. Personnel records for each employee shall contain:
 - i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.
 - ii. Documentation of training.
 - iii. Documentation of supervision and performance evaluation.
 - iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.504.7.A.
 - v. A copy of the employee's job description.
- 4. Ensure all care provided is coordinated with any other services the client is receiving.
 - a.

8.504.8 PRIOR AUTHORIZATION REQUESTS

- 8.504.8.A. The SEP case manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CLLI waiver.
- 8.504.8.B. All units of service requested shall be listed on the Support Planning form.
- 8.504.8.C. The first date for which services may be authorized is the latest date of the following:
1. The financial eligibility start date, as determined by the financial eligibility site.
 2. The assigned start date on the certification page of the Department approved assessment tool.
 3. The date, on which the client's parent(s) and/or legal guardian signs the Support Planning form or Intake form, as prescribed by the Department, agreeing to receive services.
- 8.504.8.D. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Department approved assessment tool.
- 8.504.8.E. The SEP case manager shall submit a revised PAR if a change in the Support Planning results in a change in services.
- 8.504.8.F. The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.
- 8.504.8.G. Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.
- 8.504.8.H. A revised PAR shall not be submitted if services on the Support Planning document are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.
- 8.504.8.I. If services are decreased without the client's parent(s) and/or legal guardian agreement, the SEP case manager shall notify the client's parent(s) and/or legal guardian of the adverse action and appeal rights using the LTC 803 form in accordance with the 10 day advance notice period.

8.504.9 REIMBURSEMENT

- 8.504.9.A. Providers shall be reimbursed at the lower of:
1. Submitted charges; or
 2. A fee schedule as determined by the Department.

8.506 CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM

8.506.1 Legal Basis:

The Children's Home and Community Based Services program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CHCBS program is also authorized under state law at C.R.S. § 25.5-6-901 et seq. – as amended.

8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.506.3.B and the additional operations specifically defined for this waiver in Section 8.506.4.B.

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552

8.506.3 General Definitions

- A. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved instrument to complete assessments.
- B. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs. Additional operations specifically defined for this waiver are described in Section 8.506.4.B.
- C. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency.
- D. Continued Stay Review means a reassessment by the case manager to determine the client's continued eligibility and functional level of care.
- E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital or skilled nursing facility.
- F. County Department means the Department of Human or Social Services in the county where the resident resides.
- G. Department means the Department of Health Care Policy and Financing.
- H. Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.
- I. Functional Eligibility means that the client meets the criteria for long term care services as determined by the Department's prescribed instrument.

- J. Institutional Placement means residing in an acute care hospital or nursing facility.
- K. Intake/Screening/Referral means the initial contact with individuals by the Case Management Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.
- L. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery and utilization of services.
- M. Professional Medical Information Page (PMIP) means the medical information signed by a licensed medical professional used as a component of the Department approved assessment tool to determine the client's need for institutional care.
- N. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking or receiving services of his or her rights and responsibilities.
- O. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1
- P. Utilization Review Contractor means the Department or the agency contracted with the Department to review the CHCBS waiver application for confirmation that functional eligibility and targeting criteria are met.

8.506.4 Benefits

8.506.4.A Home and Community Based Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at 26-1-114, C.R.S., as amended.
2. Case Management Agencies will complete all administrative functions of a client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.
3. Initial Referral:
 - a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible.
 - b. At the time of making the initial face-to-face contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective.
 - c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

- d. Verify that the child meets the eligibility requirements outlined in Client Eligibility, Section 8.506.6.
 - e. Submit the assessment and documentation of the enrollment application to the Utilization Review Contractor to ensure the targeting criteria and functional eligibility criteria are met. Minimum documents required:
 - i. Initial Enrollment Form
 - ii. Department prescribed Professional Medical Information Page
 - f. Submit a copy of the approved initial enrollment form to the County Department for activation of a Medicaid State Identification Number.
 - g. Develop the Support Planning document in accordance with Section 8.506.4.B.7.
 - h. Develop a Cost Containment Record in accordance with Section 8.506.12 at the time that the Support Planning is completed.
 - i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with 8.506.10.
- 4. Continued Stay Review
 - a. Complete a new Assessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved by the Utilization Review Contractor.
 - b. Review and revise the Support Planning document in accordance with Section 8.506.4.B.7.
 - c. Calculate expected costs to the Medicaid Program, as set forth in Section 8.506.12, for the redetermination period.
 - d. Notify the county technician of the renewed Long Term Care certification.
- 5. Discharge/Withdrawal
 - a. At the time that the client no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:
 - i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.
 - ii. Submit a Department designated Discharge form to the Utilization Review Contractor.
 - iii. Submit PAR termination to the Department's Fiscal Agent.
 - iv. Notify County Department of termination.
 - v. Notify agencies providing services to the client that the child has been discharged from the waiver.

6. Transfers

a. Sending agency responsibilities:

- i. Contact the receiving case management agency by telephone and provide notification that:
 - 1) The child is planning to transfer, per the parent(s) or guardian choice.
 - 2) Negotiate an appropriate transfer date.
 - 3) Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.
- ii. Using a State designated form, notify the Utilization Review Contractor of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.
- iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual (9 CCR 2503-5), Case Transfer Section 3.560.

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, § 3.560 is available at <http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=638>
9. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

b. Receiving agency responsibilities

- i. Conduct a fact-to-face visit with the child within ten (10) working days of the child's transfer, and
- ii. Review and revise the Support Planning document and the Prior Approval Cost Containment Record and change or coordinate services and providers as necessary.

7. Support Planning

- a. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community based services. A signature from the parent(s) or guardian is required on this state designated form.
- b. On a monthly basis, evaluate the effectiveness of the Support Planning document by monitoring services provided to the child. This monitoring may include:

- i. Conducting child, parent(s) or guardian, and provider interviews.
- ii. Reviewing cost data.
- iii. Reviewing any written reports received.

8.506.4.C In Home Support Services:

1. IHSS for CHCBS clients shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.
2. Family members of a client can only be reimbursed for extraordinary care.

8.506.4.D CHCBS clients are eligible for all other Medicaid state plan benefits.

8.506.5 Non-Benefit

8.506.5.A Tasks defined as Personal Care or Homemaker in Section 8.552 are not benefits of this waiver.

8.506.6 Client Eligibility

8.506.6.A An eligible client shall meet the following requirements:

1. Targeting Criteria:
 - a. Not have reached his/her eighteenth (18th) birthday.
 - b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.
 - c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.
 - d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.
2. Functional Eligibility:
 - a. The Utilization Review Contractor certifies, through the Case Management Agency completed assessment, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.
3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.
4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

8.506.6.B Financial Eligibility

1. Parental income and/or resources will result in the child being ineligible for Medicaid benefits.
2. The income and resources of the child do not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance

3. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, Long-Term Care Medical Assistance Eligibility, Consideration of Trusts in Determining Medicaid Eligibility, Section 8.100.7.E.

8.506.6.C Roles of the County Department

1. Processing the Disability Determination Application through the contracted entity determined by the Department.
2. Certify that the child's income and/or resources does not exceed 300% of SSI.
3. Ensure that the parent(s) or guardian is in contact with a case management agency.
4. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility within five (5) working days of determination.

8.506.7 Waiting List

8.506.7.A The number of clients who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.

8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

8.506.7.C The waiting list shall be maintained by the Utilization Review Contractor.

8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the Utilization Review Contractor will use for the individual's placement on the waiting list.

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the Utilization Review Contractor will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the Utilization Review Contractor that an opening for the CHCBS waiver is available the Case Management Agency shall:

1. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.
2. Update the existing functional level of care assessment in the official client record.
3. Reassess for eligibility criteria as set forth at 8.506.6.
4. Notify the Utilization Review Contractor of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.
2. Are on the waiting list for an organ transplant.
3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.
4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.8 Provider Eligibility

8.506.8.A Providers shall enter into an agreement with the Department to conform to all federal and state established standards for the specific service they provide under the HCBS-CHCBS waiver.

8.506.8.B Providers must comply with the requirements of 10 CCR 2505-10, Section 8.130.

8.506.8.C Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure statute and regulations.

8.506.8.D IHSS providers shall comply with IHSS Rules in Section 8.552.

8.506.9 Provider Responsibilities

8.506.9.A CHCBS providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining, and terminating employees;
2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section C.R.S. 19-3-307 (2016).

8.506.9.B CHCBS Providers shall:

1. Ensure a client is not discontinued or refused services unless documented reasonable efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.
2. Ensure client records and documentation of services are made available at the request of the case manager, Department, or Utilization Review Contractor.
3. Ensure that adequate records are maintained.
 - a. Client records shall contain:
 - i. Name, address, phone number and other identifying information for the client and the client's parent(s) and/or legal guardian(s).
 - ii. Name, address and phone number of child's Case Manager.
 - iii. Name, address and phone number of the client's primary physician.

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- iv. Special health needs or conditions of the client.
 - v. Documentation of the specific services provided, including:
 - a. Name of individual provider.
 - b. The location for the delivery of services.
 - c. Units of service.
 - d. The date, month and year of services and, if applicable, the beginning and ending time of day.
 - x. Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.
 - xi. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.2.
 - xii. Documentation of communication with the client's case manager.
 - xiii. Documentation of communication/coordination with any additional providers.
 - b. Personnel records for each employee shall contain:
 - i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.
 - ii. Documentation of training.
 - iii. Documentation of supervision and performance evaluation.
 - iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.506.
 - v. A copy of the employee's job description.
 - 4. Ensure all care provided is coordinated with any other services the client is receiving.
 - a.
- 8.506.9.C Responsibilities specific to IHSS Provider Agencies**
- 1. Eligible IHSS Agencies will conform to all certification standards set forth at 10 C.C.R. 2505-10, Section 8.552.5
 - 2. IHSS Agencies will adhere to all responsibilities outlined at 10 C.C.R. 2505.10, Section 8.552.6
 - 3. Ensure that only Health Maintenance Activities are delivered to CHCBS clients through the IHSS benefit.

8.506.9.D Responsibilities Specific to Case Management Agencies

1. Case Management Agencies will obtain a specific authorization to provide CHCBS case management benefits to clients as set forth in Provider Enrollment Section 8.487.
2. Verify that the IHSS care plan developed by IHSS providers is in accordance with both Sections 8.506.4.C and 8.552 of this volume.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a Prior Authorization Request (PAR) form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the Support Planning document.

8.506.10.C The first date for which services can be authorized is the latest date of the following:

1. The financial eligibility start date, as determined by the financial eligibility site.
2. The assigned start date on the certification page of the Assessment.
3. The date, on which the client's parent(s) and/or legal guardian signs the Support Planning document or Intake form, as prescribed by the Department, agreeing to receive services.

8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Assessment.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Support Planning document results in a change in services.

8.506.10.F The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.

8.506.10.G Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.

8.506.10.H A revised PAR shall not be submitted if services on the Support Planning document are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.

8.506.10.I If services are decreased without the client's parent(s) and/or legal guardian agreement, the case manager shall notify the client's parent(s) and/or legal guardian of the adverse action and appeal rights using the LTC 803 form in accordance with the 10-day advance notice period.

8.506.11 Reimbursement

8.506.11.A Providers shall be reimbursed at the lower of:

1. Submitted charges; or
2. A fee schedule as determined by the Department.

8.506.12 Cost Containment

- 8.506.12.A The Department is responsible for ensuring that, on average, services delivered to the child are within the Department's cost containment requirements for the respective level of institutional care.
- 8.506.12.B The case manager must identify costs as part of the Support Planning document. This Cost Containment Record shall be on a Department prescribed form and include all estimated:
1. Waiver benefit services and units, as defined at 8.506.2.
 2. State Plan benefit services and units.
- 8.506.12.C The costs of the benefit services identified in the Cost Containment Record shall be totaled and divided by the number of days remaining before the end of the child's current enrollment period.
- 8.506.12.D The cost per day for the child shall be compared against the Department designated cost per day of institutional care to determine cost effectiveness.
- 8.506.12.E The Case Manager will revise the child's Cost Containment Record anytime that a significant change in the Support Planning document results in an increase or change in the services to be provided.
- 8.506.12.F The Case Manager will submit the Cost Containment Record to the Utilization Review Contractor for approval at the time of the child's initial enrollment onto the CHCBS waiver, or any time that a revision to the Cost Containment Record increases by a Department prescribed amount.
- 8.506.12.G Approval of the Cost Containment Record by the Department only ensures that the cost of the services does not exceed the equivalent cost of the appropriate institutional care.
- 8.506.12.H Approval of the Cost Containment Record form does not constitute approval of Medicaid reimbursement for authorized services identified within the record.

8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

The Children's Habilitation Residential Program is a residential services and support program for children and youth who are developmentally disabled as defined in Section 27-10.5-102 (11), C.R.S. (See 8.508.170, E.) Children under the age of five who are developmentally delayed are included only when their developmental delay is accompanied by significant medical and/or behavioral needs. The children are placed through Colorado County Departments of Social/Human Services. The children are at risk of institutionalization and the program serves as an alternative to placement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

The services provided through this program serve as an alternative to ICF/MR placement for children birth to twenty-one years of age who meet the eligibility criteria and the Level of Need Screening Guidelines. The services provided through the Children's Habilitation Residential Program (CHRP) shall be limited to:

- Self-Advocacy Training
- Independent Living Training
- Cognitive Services
- Communication Services
- Counseling and Therapeutic Services
- Personal Care Services
- Emergency Assistance Training
- Community Connection Services
- Travel Services
- Supervision Services
- Respite Services

when deemed to be appropriate and adequate by the child's physician, and these services shall be provided in the community, as available.

CHRP services for children with developmental disabilities shall be provided in accordance with these rules and regulations.

8.508.10 PROGRAM ADMINISTRATION

- A. The Children's Habilitation Residential Service Program for children with developmental disabilities is administered by the Colorado Department of Human Services (CDHS), Division of Child Welfare under the oversight of the Department of Health Care Policy and Financing.
- B. CHRP services do not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services.
- C. CHRP services are subject to approval of a waiver under Section 1915c of the Social Security Act by the Center for Medicare and Medicaid Services.
- D. CHRP services are subject to annual appropriations by the Colorado General Assembly.
- E. The Department of Human Services, Division of Child Welfare shall limit the utilization of the CHRP based on:
 - 1. The federally approved capacity of the waiver;
 - 2. Cost effectiveness (see Section 8.508.80); and

3. Within the total appropriation limitations when enrollment is, projected to exceed spending authority.

8.508.20 PROGRAM PROVISIONS

Colorado has authority to provide the following services under the CHRP:

- A. CHRP services are provided as an alternative to institutional placement for children with developmental disabilities and are limited to self-advocacy training, independent living training, cognitive services, communication services, counseling and therapeutic services, personal care services, emergency assistance training, community connection services, travel services, and supervision services.
- B. Children eligible for services under the CHRP waiver are eligible for all other Medicaid services for which they qualify and must first access all benefits available under the regular Medicaid State Plan and/or Medicaid EPSDT (Early and Periodic Screening, Diagnosis and Treatment) coverage prior to accessing funding for those same services under the CHRP.
- C. Case management services will be provided by the county department as an administrative activity and include:
 1. Assessment of the individual's needs to determine if CHRP services are appropriate;
 2. Completion of the Individualized Plan (IP); and
 3. Submission of the Individualized Plan to the Colorado Department of Human Services, Division of Child Welfare Services, for review and approval for CHRP waiver services. These Individualized Plans are also subject to review by the Department of Health Care Policy and Financing.
- D. The individual receiving services and his/her family or guardian and placing County Department of Social/Human Services are responsible for participating with the services provider in:
 1. Developing the Individualized Plan;
 2. Cooperating with implementation of the service plan;
 3. Choosing to receive services through the CHRP waiver.

8.508.30 ELIGIBILITY

- A. Services shall be provided to children with developmental disabilities who meet all of the following program eligibility requirements:
 1. The child shall be determined eligible for developmental disabilities services by the appropriate Community Centered Board (CCB).
 2. The child is a Colorado child placed in foster care through a Colorado County Department of Social/Human Services by court order. This includes children placed through a voluntary agreement with the Colorado County Department of Social/Human Services while awaiting the court to take jurisdiction.

3. Waiver services to individuals age eighteen to 21 will be provided if the individual is in a court-ordered foster care placement through the County Department of Social/Human Services and the court order is in effect when the child reaches his/her eighteenth birthday.
 4. The child is at risk of or has been reported/found to be abused and/or neglected or dependent, as defined in 19-3-102, C.R.S.
 5. The child shall meet the out-of-home placement criteria as defined in Section 7.304.3, Colorado Department of Human Services Social Services Staff Manual (12 CCR 2509-4).
 6. The child shall meet the Target Group for Program Areas 4, 5, or 6 as outlined in 7.201.2, 7.202.2 and 7.203.21, Colorado Department of Human Services Staff Manual (12 CCR 2509-3).
 7. The Level of Need checklist documents that the child/youth is in need of the services available through the waiver.
 8. The CDHS CHRP waiver administrator verifies through the CHRP waiver eligibility process, including the ULTC 100 and LTC 102 - CHRP that the child meets the established minimum eligibility criteria for ICF/MR placement.
 9. The child's eligibility for Supplementary Security Income (SSI) benefits is established.
 10. The income of the child does not exceed 300% of the current maximum SSI standard maintenance allowance.
 11. The resources of the child do not exceed the maximum SSI allowance.
 12. The child's eligibility for Colorado Medicaid is established and reported in the Child Welfare automated system.
 13. Enrollment of a child in the CHRP will result in an overall savings when compared to the ICF/MR cost as determined by the State.
 14. The child receives at least one waiver service each month.
- B. Pursuant to the terms of the Children's Residential Habilitation Program (CHRP), the number of individuals who may be served each year in the CHRP is based on criteria found in Section 8.508.10(E).

8.508.40 WAITING LIST PROTOCOL

Children determined eligible for services under the CHRP which are not immediately available within the federally approved capacity limits of the waiver shall be eligible for placement on a waiting list in the order in which the eligible application was received by the CDHS CHRP waiver administrator. Guardians of applicant children denied program enrollment shall be informed of their appeal rights in accordance with Section 8.057 of this Staff Manual.

When an opening becomes available, the first child on the waiting list shall be reassessed for eligibility by the CDHS CHRP waiver administrator and, if determined to still be eligible, assigned that opening.

8.508.50 RESPONSIBILITIES OF THE COUNTY DEPARTMENTS OF SOCIAL SERVICES

The County Department of Social/Human Services shall:

- A. Ensure that the eligibility requirements as defined in 8.503.30, A, 1 through 8 are met;
- B. Submit eligibility applications to the CDHS CHRP waiver administrator with a request for enrollment or placement on the waiting list.
- C. Provide services to children in out-of-home placement and their families as required in CDHS Social Services Staff Manual (12 CCR 2509-4, 7.300 Child Welfare Services).
- D. Determine whether a familial relationship as defined in 27-10.5-102, C.R.S. exists, between the licensed or certified provider and the child.
- E. Determine prior to referring to CHRP, that the extraordinary service, needs of the child exceed the maximum reimbursement the County Department of Social/Human Services is able to negotiate based on the child's individualized needs as authorized in 26-5-104(6), C.R.S. The County Department of Social/Human Services must negotiate based on the child's. need and the service provider's ability to meet the needs.
- F. Exhaust appropriate community services available to the children before requesting similar services from the waiver.

8.508.60 RESPONSIBILITIES OF THE COMMUNITY CENTERED BOARD

The Community Centered Board (CCB) shall make a determination of eligibility for developmental disabilities services for any child being considered for enrollment in the Children's Habilitation Residential Program who is referred by a County Department of Social/Human Services.

8.508.70 INDIVIDUALIZED PLAN (IP)

A written IP describes the medical and other services to be furnished, their frequency, and the type of provider who will furnish each.

8.508.71 CONTENT OF THE INDIVIDUALIZED PLAN

- A. The Individualized Plan (IP) shall consist of a Child's Needs Section, a Plan Section, and an Expected Outcomes Section.
 - 1. Child's Needs Section shall identify and list specific conditions (needs) for which services and supports are needed to maintain the child in the community setting. The areas of needs shall contain and not be limited to:
 - a. medical needs;
 - b. functional needs; and
 - c. safety needs.
 - 2. Plan Section shall:
 - a. Identify and quantify all services and supports to be provided to meet the child's needs; and
 - b. Identify the name or type of provider of services;
 - c. Identify payment responsibilities for the services, e. g., Parent, County Department of Social/Human Services, CHRP.

3. Expected Outcomes Section shall be a statement of measurable objectives expected to be obtained during the period covered by the Individualized Plan.
- B. The Individualized Plan shall include the date and signatures of the provider, the guardian, the County Department of Social/Human Services, and the child when appropriate.
- C. The provider shall calculate the total costs to the Children's Habilitation Residential Program, utilizing Individualized Plan document. The costs to implement the Individualized Plan shall not include room, board, and personal needs allowance.

8.508.72 REVISIONS TO INDIVIDUALIZED PLAN

- A. When a change in the Individualized Plan results in an increase in the costs of services/supports being provided, the County Department of Social Services may seek telephone approval from the Department of Human Services, Division of Child Welfare Services. Final authorization is contingent upon submission and approval of a revised Individualized Plan to the Division of Child Welfare Services within ten working days. Continued cost effectiveness must be demonstrated when there is an increase in costs.
- B. When a change results in a decrease in the costs of CHRP services, a revised Individualized Plan must be submitted to the CDHS, Division of Child Welfare Services within ten working days of the change.
- C. CDHS shall approve or disapprove the revised maximum authorization of services within thirty (30) calendar days of receipt of the revised IP. If there is an emergency need, the provider shall telephone the CDHS, Division of Child Welfare Services and request an expedited review.

8.508.73 REIMBURSEMENT

Only services identified on the Individualized Plan are available for reimbursement under CHRP. Reimbursement will be made only to licensed or certified providers, as defined in Section 8.508.160 and services will be reimbursed on a daily rate basis through the Medical Management Information System (MMIS) for the habilitative services. Medicaid shall not pay for room and board. The equivalent of the full federal SSI benefit will provide for the room, board and personal needs allowance. Education costs will be reimbursed through the Department of Education and not by the Colorado Department of Human Services or Medicaid.

8.508.80 COST CONTAINMENT

Cost containment is to ensure, on an individual child basis, that the provision of CHRP services is a cost effective alternative compared to the equivalent cost of appropriate ICF/MR institutional level of care. The provider must identify costs as part of each Individualized Plan to be submitted to the CDHS for review. The State shall be responsible for ensuring that, on average, each plan is within the federally approved cost containment requirements of the waiver. Children enrolled in the CHRP shall continue to meet the cost containment criteria during subsequent periods of eligibility.

- A. The completed enrollment forms shall be submitted to the County Department of Social/Human Services CHRP waiver administrator. A complete packet includes a copy of the:
 1. Individual Choice Statement.
 2. Individualized Plan; within 30 calendar days.
 3. Level of Need document.

4. ULTC 100.2 form.
 5. Request for Enrollment.
- B. The county department CHRP waiver administrator will immediately submit enrollment documentation to the CDHS CHRP waiver administrator for verification of eligibility. A complete packet includes a copy of the:
1. ULTC 100.2; and
 2. Request for Enrollment; and
 3. Individual Choice Statement
 4. Individualized Plan within 45 calendar days.
- C. The effective date/enrollment date shall be no earlier than the start date on the CDHS CHRP waiver administrator's ULTC 100.2 verification form. No services may be authorized prior to the date of enrollment
- D. An Individualized Plan and ULTC 100.2 verification may be valid for no more than a twelve (12) month period.

8.508.100 SERVICE DESCRIPTIONS

- A. Self-advocacy training may include training in expressing personal preferences, self-representation, individual rights and making increasingly responsible choices. It may also include team building with volunteers, professionals, and/or family members to examine changing roles as service models shift from the traditional supervision/control model to a self-actualization model.
- B. Independent living training may include training in personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone, using sign language, facilitated communication, reading, and letter writing.
- C. Cognitive services may include training with money management and personal finances, planning and decision-making.
- D. Communication services may include professional training and assistance to maintain or improve communication skills. It may include a professional or individual who provides interpretation and facilitated communication services.
- E. Counseling and therapeutic services may include individual and/or group counseling, behavioral or other therapeutic interventions directed at increasing the overall effective functioning of an individual.
- F. Personal care services may include any personal care functions requiring training/assistance by an RN, LPN, or Certified Nurse Aide. It may also include operating, maintaining, and training in the use of medical equipment.
- G. Emergency assistance training includes developing responses in case of emergencies, prevention planning and training in the use of equipment or technologies used to access emergency response systems.

- H. Community connection services may explore community services available to the individual, and develop methods to access additional services/supports/activities desired by the individual. Community connection services can provide the individual with the resources to participate in the activities and functions of the community desired and chosen by the individual receiving the services. Typically, these will be the same type of activities available and desired by the general population.
- I. Travel services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to services and supports identified in the IP.
- J. Supervision services may include a person safeguarding an individual with developmental disabilities and/or utilizing technology for the same purpose.
- K. Respite Services: Services that are provided to an eligible client on a short term basis because of the absence or need for relief of those persons normally providing the care. Respite services may be approved for up to 30 days a calendar year for each eligible client.
- L. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code.
- M. Only those services not available under Medicaid EPSDT, Medicaid State plan benefits, third party liability coverage, or other state funded programs, services or supports are available through the Children's Habilitation Residential Program (CHRP) Waiver. Appropriate community services must be exhausted before requesting similar services from the waiver. The CHRP Waiver does not reimburse services that are the responsibility of the Colorado Department of Education.

8.508.110 MAINTENANCE OF CASE RECORDS

- A. Copies of the ULTC 100.2 shall be maintained by the County Department of Social/Human Services and the CDHS Division of Child Welfare Services. In addition, the County Department of Social/Human Services shall maintain a copy of the Individualized Plan and Level of Need Checklist for the Children's Habilitation Residential Program. A copy of the ULTC 100.2 verification form shall be maintained by the provider.
- B. Copies of evaluations and re-evaluations shall be maintained for a minimum period of three years by those cited in 8.508.110, A, with the exception of providers who are required to maintain records for a period of six years from the date services are rendered.
- C. Confidentiality of records shall be maintained in accordance with Section 8.100.8 of this manual, as well as with CDHS Social Services Staff Manual, Section 7.000.72 (12 CCR 2509-1).
- D. Documentation of case activity shall also meet requirements of CDHS, Division of Child Welfare Services as outlined in the CDHS Social Services Staff Manual, Section 7.000.72 (12 CCR 2509-1).

8.508.120 REDETERMINATION OF ELIGIBILITY

Redetermination of eligibility for CHRP services shall be made as follows:

- A. At least annually and one (1) month prior to the expiration of the ULTC 100.2 form, the County Department of Social/Human Services CHRP waiver administrator shall ensure that a new ULTC 100.2 form is submitted to the CDHS CHRP waiver administrator for verification if there is no significant change in the child's condition.
- B. At least annually, the County Department of Social/Human Services shall verify the child's continued Medicaid eligibility.

8.508.121 REASSESSMENT

A reassessment to redetermine or confirm a child's eligibility for the CHRP Program must be conducted, at a minimum, every twelve (12) months and the following shall be renewed/revised and submitted to the county department CHRP waiver administrator no later than one (1) month prior to the expiration of the previous/current ULTC 100.2 verification form:

- A. Individualized Plan
- B. Copy of the Level of Need worksheet
- C. Copy of the ULTC 100.2
- D. The county department CHRP waiver administrator shall submit a copy of the Individualized Plan to the CDHS CHRP waiver administrator.

8.508.130 TRANSFER PROCEDURES BETWEEN COUNTY DEPARTMENTS OF SOCIAL SERVICES

Transfer of cases shall occur in accordance with CDHS Social Services Staff Manual, Section 7.000.6, D (12 CCR 2509-1).

8.508.140 DISCONTINUATION FROM CHRP

- A. A child shall be discontinued from the CHRP Program when one of the following occurs:
 - 1. The child no longer meets one of the criteria as outlined in Section 8.508.30 of these rules;
 - 2. The costs of services and supports provided in the community exceed the cost effectiveness criteria of the program;
 - 3. The child enrolls in another HCBS waiver program or is admitted for a long-term stay in an institution (e.g., hospital); or
 - 4. The child reaches his/her 21st birthday or transitions into DDS Adult Residential Services.
- B. The County Department of Social/Human Services shall inform the child's parent(s) or guardian in writing on a form provided by the State of discontinuation from the CHRP Program, at least ten (10) calendar days before the effective date of discontinuation. The child's parent or guardian shall also be informed of his/her appeal rights as contained in the Home and Community Based Services - Client's Rights section of this Staff Manual. The reason and regulation supporting the discontinuation shall be clearly identified on this notice.

- C. Whenever a child is discontinued from the CHRP, the County Department of Social/Human Services shall notify all providers listed on the IP within ten (10) calendar days prior to the effective date of discontinuation; and shall notify the CDHS Division of Child Welfare Services within ten (10) calendar days, on a State designed form.
- D. The reason for discontinuation shall be documented in the child's case record.

8.508.150 MONITORING AND COORDINATION

- A. County Departments of Social/Human Services shall document whether and how the services provided are meeting the child's needs, as defined in the IP. Documentation requirements shall be the same as those outlined in CDHS Social Services Staff Manual, Section 7.002.1 (12 CCR 2509-1), related to case planning.
- B. County Departments of Social/Human Services shall be responsible to coordinate information with the parent(s) or guardian, primary physician, service providers, community centered boards, Social Security Administration and others as necessary to ensure the effective delivery of services to the child.

8.508.160 SERVICE PROVIDERS

- A. Children's Habilitation Residential Program services shall be provided by the following residential provider types which shall meet all of the certification, licensing and Quality Assurance regulations related to the provider type as outlined in CDHS Social Services Staff Manual, Section 7.701 (12 CCR 2509-8):
 - 1. Family Foster Care Homes, as defined by the waiver, and certified and supervised by County Departments of Social Services or Child Placement Agencies (CPAs).
 - 2. Residential Child Care Facilities licensed through the CDHS Division of Child Care.
 - 3. Specialized group facilities licensed by the Division of Child Care and supervised by County Departments of Social/Human Services or Child Placement Agencies.
- B. Children's Habilitation Residential Program Service Providers may also include Providers as defined in Section 8.500.5 of this Staff Manual. Home and Community Based Services for the Developmentally Disabled (HCBS- DD) programs will be provided by agencies that meet the following criteria:
 - 1. Have received and/or maintained program approval from the Colorado Department of Human Services, Division for Developmental Disabilities Services for the provision of HCBS-DD waiver services; and
 - 2. Have a Medicaid Provider Agreement; and
 - 3. Have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S. and all the rules and regulations promulgated thereunder; and
 - 4. Have, if applicable, the current required license from the Colorado Department of Public Health and Environment.
- C. Service providers shall cooperate in all of the areas identified in Section 8.500.52.
- D. All eligible providers shall have a Medicaid Provider Agreement.

- E. Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department of Health Care Policy and Financing, and shall have written policies and procedures regarding emergency procedures.
- F. Service providers shall not be family members as defined in §27-10.5-102(15), C.R.S. for the children they serve in the waiver.
- G. When a qualified provider contracts with or utilizes the services of a professional, individual, or vendor to augment a child's services under the waiver the definitions and qualifications contained in Section 8.508.170 apply.
- H. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.508.170 DEFINITIONS

Habilitative services are defined as those services which are recommended by a licensed practitioner, as defined in §26-4-527(3), C.R.S. to assist clients with developmental disabilities eligible under the State Plan to achieve their best possible functional level. All clients of Residential habilitation services and supports will receive some type of habilitation services in order to acquire, retain, or improve self- help, socialization, or other skills needed to reside in the community. Some clients may receive a combination of habilitative services (skill building) and support services (a task performed for the client, where learning is secondary or incidental to the task itself).

- A. Assessment: The process of collecting and evaluating information for the purpose of developing an individual child plan on which to base services and referral. The assessment process is both initial and ongoing.
- B. Case Management: Activities that are intended to ensure that clients receive the services they need, that services are coordinated, and that services are appropriate to the changing needs and stated desires of the clients and families over time. The goals of case management are: 1) to bring about positive changes in client's status; 2) to assist clients in reaching their highest potential; and 3) to achieve the best possible quality of life for clients and their families in the community. Goals are developed to the extent possible among case managers, referral sources, families and clients.
- C. Client: A child or youth who is receiving habilitative services in the Children's Habilitation Residential Program.
- D. County Caseworker: A designated representative from the local County Department of Social/Human Services.
- E. Developmental Disability: A disability that is manifested before the child reaches twenty-two years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include 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 mental retardation. It includes children less than five years of age with slow or impaired development at risk of having a developmental disability.
- F. Family: Defined in 27-10.5-102, C.R.S.

- G. Family Foster Care Home: A family care home providing 24-hour care for a child or children. It is a facility certified by either a County Department of Social/Human Services or a child placement agency. A family foster care home, for the purposes of this waiver, shall not be a family member as defined in 27-10.5-102(15), C.R.S.

Qualifications: A qualified family foster home shall adhere to the service provision requirements of this waiver, as well as those specified and contained in CDHS Social Services Staff Manual (12 CCR 2509-6, 7.500 Resource Development).

- H. Individual: Any person, such as a co-worker, neighbor, etc., who does not meet definition of a family member as described in 27-10.5-102(15). C.R.S.

Qualifications: Any individual providing a service or support must receive training commensurate with the service or support to be provided and must meet any applicable state licensing and/or certification requirements.

- I. Level of Need Worksheet: A format to assess the child's level of need for services.

- J. Professional: Any person, except a family member as described in 27-10.5-102(15), C.R.S. performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

Qualifications: Any person performing a professional service must possess any and all license(s) and/or certifications(s) required by the State of Colorado for the performance of that profession or professional service.

- K. Programming: A plan that provides intensive, comprehensive, longitudinal instruction to help the child achieve his or her best possible functioning level.

- L. Vendor: The supplier of a product or services to be purchased for a recipient of services under this waiver.

Qualifications: In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards. In addition, such expenses over \$1,000 should be chosen through a bid process. When a bid process is used and the lowest bid is not chosen, proper justification for selection of a vendor with a higher bid must be documented.

8.508.180 CHILDREN'S RIGHTS

Clients rights are defined in this section to provide the fullest possible measure of privacy, dignity and other rights to persons undergoing care and treatment in the least restrictive environment.

- A. Advisement of Children's Rights: Each authorized facility shall have written policy and procedures which address and ensure the availability of each of the following rights for clients in residence.
- B. All children and their guardians receiving services through the CHRP shall be advised in writing of the following rights on admission.
1. A written copy of his or her rights shall be furnished;
 2. A list of such rights shall be posted prominently in the facility and translated into Spanish or any other appropriate language as needed.

3. A child may be photographed upon admission for identification and administrative purposes of the facility. No other non-medical photographs shall be taken or used without the written consent of the client's parent or legal guardian.
 4. Every client has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status or disability.
 5. Every child's guardian has the right to request to see the child's medical records, to see the records at reasonable times, and to be given written reasons if the request is denied.
- C. Children's Rights as defined in CDHS Social Services Staff Manual, Section 7.714.50, "CHILDREN'S RIGHTS" (12 CCR 2509-8) shall also apply.

8.508.190 APPEALS

An individual who has applied for or is receiving CHRP services has a right to the appeal process established in Section 8.058 of this Manual. When an individual disagrees with a Community Centered Board (CCB) determination of developmental disability services, the dispute resolution process in the Colorado Department of Human Services, Developmental Disabilities Services rules and regulations shall apply. Section 16.320 (2 CCR 503-1).

8.509 HOME AND COMMUNITY BASED SERVICES FOR COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS)

8.509.10 GENERAL PROVISIONS

8.509.11 LEGAL BASIS

- A. The Home and Community Based Services for COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS) program in Colorado is authorized by a waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CMHS program is also authorized under state law at 25.5-6-601 through 25.5-6-607, C.R.S. (2012). The number of recipients served in the HCBS-CMHS program is limited to the number of recipients authorized in the waiver.
- B. All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the Social Security Act of 1935 and 45 CFR Part 1397 (October 1, 1991), by possession of a valid Assisted Living Residence license issued under 25-27-105, C.R.S. (1999), and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains with electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO, 80203. Additionally, any incorporated material in these rules may be examined at any State depository library.

8.509.12 SERVICES PROVIDED [Eff. 7/1/2012]

- A. HCBS-CMHS services provided as an alternative to nursing facility placement include:
 - 1. Adult Day Services
 - 2. Alternative Care Facility Services (which includes Homemaker and Personal Care services)
 - 3. Consumer Directed Attendant Support Services (CDASS)
 - 4. Electronic Monitoring
 - 5. Home Modification
 - 6. Homemaker Services
 - 7. Non-Medical Transportation
 - 8. Personal Care
 - 9. Respite Care
- B. Case management is not a service of the HCBS-CMHS program, but shall be provided as an administrative activity through case management agencies.
- C. HCBS-CMHS clients are eligible for all other Medicaid State plan benefits.

8.509.13 DEFINITIONS OF SERVICES

- A. Adult Day Services is defined at Section 8.491, ADULT DAY SERVICES.
- B. Alternative Care Facility Services is defined at Section 8.495, ALTERNATIVE CARE FACILITY.
- C. Consumer Directed Attendant Support Services (CDASS) is defined at Section 8.510, CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES
- C. Electronic Monitoring services is defined at Section 8.488, ELECTRONIC MONITORING.
- D. Home Modification is defined at Section 8.493, HOME MODIFICATION.
- E. Homemaker Services is defined at Section 8.490, HOMEMAKER SERVICES.
- F. Non-Medical Transportation is defined at Section 8.494, NON-MEDICAL TRANSPORTATION.
- G. Personal Care is defined at Section 8.489, PERSONAL CARE.
- H. Respite is defined at Section 8.492, RESPITE.

8.509.14 GENERAL DEFINITIONS

- A. Assessment shall be defined as a client evaluation according to requirements at Section 8.509.31, (B).
- B. Case Management shall be defined as administrative functions performed by a case management agency according to requirements at Section 8.509.30.
- C. Case Management Agency shall be defined as an agency that is certified and has a valid contract with the state to provide HCBS-CMHS case management.
- D. Case Plan shall be defined as a systematized arrangement of information which includes the client's needs; the HCBS-CMHS services and all other services which will be provided, including the funding source, frequency, amount and provider of each service; and the expected outcome or purpose of such services. This case plan shall be written on a state-prescribed case plan form.
- E. Categorically Eligible, shall be defined in the HCBS-CMHS Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-CMHS as three hundred percent eligible persons, as defined at 8.509.14(S).
- F. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.
- G. Uncertified Congregate Facility is a facility as defined in Section 8.509.14(F) that is not certified as an Alternative Care Facility, which is defined at Section 8.495.11.
- H. Continued Stay Review shall be defined as a re-assessment as defined at Section 8.402.60.
- I. Cost Containment shall be defined at Section 8.485.50(J)

- J. Department shall be defined as the State Agency designated as the Single State Medicaid Agency for Colorado, or any division or sub-units within that agency, or another state agency operating under the authority of a memorandum of understanding with the Single State Medicaid Agency.
- K. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-CMHS waiver. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected the HCBS-CMHS waiver.
- L. Diverted shall be define as HCBS-CMHS waiver recipients who were not deinstitutionalized, as defined at Section 8.485.50(K).
- M. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) shall be defined as services provided in a home or community based setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing facility care without the provision of HCBS-CMHS, and for whom HCBS-CMHS services can be provided at no more than the cost of nursing facility care.
- N. Intake/Screening/Referral shall be as defined at Section 8.390.1(J) and as the initial contact with clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long term care client assessment.
- O. Level Of Care Screen shall be described as an assessment in Section 8.401.
- P. Non-Diversion shall be defined as a client who was certified by the Utilization Review Contractor (URC) as meeting the level of care screen and target group for the HCBS-CMHS program, but who did not receive HCBS-CMHS services for some other reason.
- Q. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8393.6 and 8.487 are met.
- R. Reassessment shall be defined as a periodic revaluation according to the requirements at Section 8.509.32. C.
- S. Three Hundred Percent (300%) Eligible persons shall be defined as persons:
- 1) Whose income does not exceed 300% of the SSI benefit level, and
 - 2) Who, except for the level of their income, would be eligible for an SSI payment; and
 - 3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty (30) consecutive days.

8.509.15 ELIGIBLE PERSONS

- A. HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements below:
1. Financial Eligibility

Clients shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual of the Colorado Department of Human Services at 9 CCR 2503-1, and the Colorado Department of Health Care Policy and Financing regulations at 10 CCR 2505-10, Section 8.100, MEDICAL ASSISTANCE ELIGIBILITY.

2. Level of Care AND Target Group.

Clients who have been determined to meet the level of care AND target group criteria shall be certified by the Utilization Review Committee (URC) as functionally eligible for HCBS-CMHS. The URC shall only certify HCBS-CMHS eligibility for those clients:

- a. Determined to meet the target group definition, defined as a person experiencing a severe and persistent mental health need that requires assistance with one or more Activities of Daily Living (ADL);
 - i. A person experiencing a severe and persistent mental health need is defined as someone who:
 - 1) Is 18 years of age or older with a severe and persistent mental health need; and
 - 2) Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM -5); and
 - a) Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and
 - b) Has resulted in functional impairment which substantially interferes with or limits one or more major life activities.
 - ii. A severe and persistent mental health need does not include:
 - 1) Intellectual or developmental disorders; or
 - 2) Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.
- b. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11-15; and
- c. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.

3. Receiving Services

- a. Only clients who receive HCBS-CMHS services, or who have agreed to accept HCBS-CMHS services as soon as all other eligibility criteria have been met, are eligible for the HCBS-CMHS program.
- b. Case management is not a service and shall not be used to satisfy this requirement.

- c. Desire or need for home health services or other Medicaid services that are not HCBS-CMHS services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.
 - d. HCBS-CMHS clients who have not received HCBS-CMHS services for thirty (30) days shall be discontinued from the program.
- 4. Institutional Status
 - a. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-CMHS services while residing in such institutions.
 - b. A client who is already an HCBS-CMHS recipient and who enters a hospital may not receive HCBS-CMHS services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the client from the HCBS-CMHS program.
 - c. A client who is already an HCBS-CMHS recipient and who enters a nursing facility may not receive HCBS-CMHS services while in the nursing facility;
 - 1) The case manager must terminate the client from the HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ULTC-100.2 for the nursing facility placement, as verified by telephoning the URC.
 - 2) A client receiving HCBS-CMHS services who enters a nursing facility for Respite Care as a service under the HCBS-CMHS program shall not be required to obtain a nursing facility ULTC-100.2, and shall be continued as an HCBS-CMHS client in order to receive the HCBS-CMHS service of Respite Care in a nursing facility.
- 5. Cost-effectiveness

Only clients who can be safely served within cost containment, as defined at Section 8.509.14 (I), are eligible for the HCBS-CMHS program. The equivalent cost of nursing facility care is calculated by the State, according to Section 8.509.19.

8.509.16 START DATE

The start date of eligibility for HCBS-CMHS services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which HCBS-CMHS services can be reimbursed shall be the LATER of any of the following:

- A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.
- B. Level of Care This date is determined by the official URC stamp and the URC-assigned start date on the ULTC 100.2 form.
- C. Receiving Services This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept HCBS-CMHS services.

- D. Institutional Status HCBS-CMHS eligibility cannot precede the date of discharge from the hospital or nursing facility.

8.509.17 CLIENT PAYMENT OBLIGATION - POST ELIGIBILITY TREATMENT OF INCOME (PETI)

When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, of Staff Manual Volume 8, the State may reduce Medicaid payment for Alternative Care Facility services according to the procedures at Section 8.509.31, E, of Staff Manual Volume 8.

8.509.18 STATE PRIOR AUTHORIZATION OF SERVICES

- A. Upon receipt of the Prior Authorization Request (PAR), as described at Section 8.509.31(G), the state or its agent shall review the PAR to determine whether it is in compliance with all applicable regulations, and whether services requested are consistent with the client's documented medical condition and functional capacity, and are reasonable in amount, frequency, and duration. Within ten (10) working days the State or its agent shall:
1. Approve the PAR and forward signed copies of the prior authorization form to the case management agency, when all requirements are met;
 2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear, or incorrect; or if services requested are not adequately justified;
 3. Disapprove the PAR when all requirements are not met Services shall be disapproved that are duplicative of other services that the client is receiving or services for which the client is receiving funds to purchase Services shall also be disapproved if all services, regardless of funding source, total more than twenty-four hours per day care.
- B. When services are disapproved, in whole or in part the Department or its agent shall notify the case management agency. The case management agency shall notify the client of the adverse action and the appeal rights on a state-prescribed form, according to Section 8.057, et seq.
- C. Revisions received by the Department or its agent six (6) months or more after the end date shall always be disapproved.
- D. Approval of the PAR by the Department or its agent shall authorize providers of services under the case plan to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for long term care medical assistance (Medicaid) on the dates of service; and upon providers' use of correct billing procedures.

8.509.19 STATE CALCULATION OF COST-CONTAINMENT AMOUNT

- A. The State shall annually compute the equivalent monthly cost of nursing facility care according to Section 8.485.100.
- B. LIMITATIONS ON PAYMENT TO FAMILY
1. In no case shall any person be reimbursed to provide HCBS-CMHS services to his or her spouse.
 2. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-CMHS program

subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

3. The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.
4. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:
 - a. The total number of Medicaid personal care units for a member of the client's family shall not exceed the equivalent of 444 personal care units per annual certification for HCBS-CMHS.
 - b. The maximum shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision and all other administrative costs.
 - c. The maximum number of personal care units per annual certification for HCBS-CMHS shall be 444 units. Family members must average at least 1.2164 hours of care per day (as indicated on the client's care plan) in order to receive the maximum reimbursement.
 - d. If the certification period for HCBS-CMHS is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the client is receiving care by the average units per day for a full year ($444/365=1.2164$).
5. If two or more HCBS-CMHS clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.
6. When HCBS-CMHS funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance cannot be used to reimburse the family.
7. Services other than personal care shall not be reimbursed with the HCBS-CMHS funds when provided by the client's family.
8. Services other than personal care shall not be reimbursed with the HCBS-CMHS funds when provided by the client's family.

C. CLIENT RIGHTS

1. The case manager shall inform clients eligible for HCBS-CMHS in writing, of their right to choose between HCBS-CMHS services and nursing facility care; and
2. The case manager shall offer clients eligible for HCBS-CMHS, the free choice of any and all available and qualified providers of appropriate services.

8.509.20 CASE MANAGEMENT AGENCIES

- A. The requirement at Section 8.390 et. seq. shall apply to the case management agencies performing the case management functions of the HCBS-CMHS program.

8.509.21 CERTIFICATION

- A. Case management agencies shall be certified, monitored and periodically recertified as required in Section 8.394 et. seq.
- B. Case management agencies must have provider agreements with the Department that are specific to the HCBS-CMHS program.

8.509.22 REIMBURSEMENT

Case management agencies shall be reimbursed for case management activities according to Section 8.392 et. seq.

8.509.30 CASE MANAGEMENT FUNCTIONS

8.509.31 NEW HCBS-CMHS CLIENTS

A. INTAKE/SCREENING/REFERRAL

- 1. Case management agency staff shall complete a State-prescribed Intake form in accordance with the Single Entry Point Intake Procedures at Section 8.393.21 for each potential HCBS-CMHS applicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the applicant for purposes of establishing a start date. Additionally, at intake, clients shall be offered an opportunity to identify a third party to receive client notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to clients.
- 2. Case management agency staff shall verify the individual's current financial eligibility status, or refer the client to the county department of social services of the client's county of residence for application. This verification shall include whether the applicant is in a category of assistance that includes financial eligibility for long term care.
- 3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long term care client assessment (ULTC-100.2), and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request an assessment if the client disagrees with the case manager's decision.
- 4. If the case management agency staff has determined that a comprehensive uniform long term care client assessment (ULTC-100.2) is needed, or if the client requests an assessment, a case manager shall be assigned to schedule the assessment

B. ASSESSMENT

- 1. The URC/SEP case manager shall complete the Uniform Long Term Care Client Assessment Instrument (ULTC 100.2) in accordance with Section 8.393.22, ASSESSMENT.
- 2. The URC/SEP case manager shall begin and complete the assessment within ten (10) days of notification of client's need for assessment.
- 3. The URC/SEP case manager shall complete the following activities for a comprehensive client assessment:

- a. Obtain all required information from the client's medical provider including information required for target group determination;
- b. Determine the client's functional capacity during a face-to-face interview, preferably with the observation of the client in his or her residential setting;
- c. Determine the ability and appropriateness of the client's caregiver, family, and other collateral, to provide the client assistance in activities of daily living;
- d. Determine the client's service needs, including the client's need for services not provided under HCBS-CMHS
- e. If the client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;
- f. Review service options based on the client's needs, the potential funding sources, and the availability of resources;
- g. Explore the client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;
- h. View and document the current Assisted Living Residence license, if the client lives, or plans to live, in a congregate facility as defined at Section 8.509.14 in order to assure compliance with the regulation at Section 5.509.11(B).
- i. Determine and document client preferences in program selection;
- j. Complete documentation on the ULTC 100.2 form.
- k. To de-institutionalize a client who is in a nursing facility under payment by Medicaid, and with a current ULTC 100.2 already certified by the URC/SEP agency for the nursing facility level of ULTC 100.2 completion date is older than six (6) months, the URC/SEP case manager shall complete a new ULTC 100.2 and determine if the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-CMHS, the case manager must obtain a new ULTC 100.2 and the client shall be treated as an applicant from the community rather than as a de-institutionalized client.
- l. It is the URC/SEP case manager's responsibility to assess the behaviors of the client and assure that community placement is appropriate.

C. HCBS-CMHS DENIALS AND/OR DISCONTINUATIONS

- 1. If a client is determined, at any point in the assessment process, to be ineligible for HCBS-CMHS according to any of the requirements at Section 8.509.15, the case manager shall refer the client or the client's designated representative to other appropriate services. Clients who are denied HCBS-CMHS services shall be notified of denials and appeal rights as follows:

a. Financial Eligibility

The income maintenance technician at the county department of social services shall notify the applicant of denial for reasons of financial eligibility, and shall inform the applicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.

b. Level of Care AND Target Group

The URC shall notify the applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the applicant of appeal rights in accordance with Section 8.057. The case manager shall not make judgments as to eligibility regarding level of care or target group, and shall refer all applicants who request a URC review to the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.

c. Receiving Services

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determines that the applicant does not meet the HCBS-CMHS eligibility requirements at Section 8.509.15 and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

d. Institutional Status

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement at Section 8.509.15, and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

e. Cost-effectiveness

The case manager shall notify the applicant of denial, on State-prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement 8.509.15 and shall inform the applicant of appeal rights in accordance with Section 8.057, et.seq. The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available, and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-CMHS eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the URC in regard to level of care and target group determination.

f. Waiver Cap

The case manager shall notify the applicant of denial, on a State-prescribed form, when the waiver cap limiting the number of clients who may be served under the terms of the approved waiver has been reached.

D. SERVICE PLANNING

1. Service Planning shall be defined in accordance with case planning at Section 8.393.23 and shall include, but not be limited to, the following tasks:
 - a. The identification and documentation of service plan goals and client choices;
 - b. The identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, finding source, and services needed but not available;
 - c. Documentation of the client's choice of HCBS-CMHS services, nursing home placement, or other services, including a signed statement of choice from the client;
 - d. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;
 - e. The formalization of the service plan agreement on a State-prescribed service plan form, including appropriate signatures;
 - f. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision;

- g. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community;
 - h. The explanation of complaint procedures to the client.
- 2. The case manager shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

E. CALCULATION OF CLIENT PAYMENT (PETI)

- 1. The case manager shall calculate the client payment (PETI) for 300% eligible HCBS-CMHS clients according to the following procedures:
 - a. For 300% eligible HCBS-CMHS clients who are not Alternative Care Facility clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.
 - b. For 300% eligible clients who are Alternative Care Facility clients, the case manager shall complete a State-prescribed form which calculates the client payment according to the following procedures:
 - 1) An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid: and
 - 2) For an individual with financial responsibility for only a spouse, an amount equal to the state Aid to the Needy Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income: or
 - 3) For an individual with financial responsibility for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding income from part-time employment earnings of a dependent child who is either a full-time student of a part-time student as defined at Section 8.100.3.L.2.d.) shall be deducted from the client's gross income; and
 - 4) Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the client's gross income as follows:
 - a) Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS: deductible or co-insurance charges: and
 - b) Necessary dental care not to exceed amounts equal to actual expenses incurred: and

- c) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred: and
- d) Medications, with the following limitations:
 - (1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.
 - (2) Medications which may be purchased with the client's Medical Identification Card shall not be allowed as deductions.
 - (3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.
 - (4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.
 - (5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.
- e) Other necessary medical or remedial care shall be deducted from the client's gross income, with the following limitations:
 - (1) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.
 - (2) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.
- f) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

- g) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.
 - 5) Any remaining income shall be applied to the cost of the Alternative Care Facility services, as defined at Section 8.495, and shall be paid by the client directly to the facility; and
 - 6) If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the client's income, the remaining income shall be kept by the client and may be used as additional personal needs or for any other use that the client desires, except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services.
2. Case managers shall inform HCBS-CMHS Alternative Care Facility clients of their client payment obligation on a form prescribed by the state at the time of the first assessment visit by the end of each plan period; or within ten (10) working days whenever there is a significant change in the client payment amount. Significant change is defined as fifty dollars (\$50) or more. Copies of client payment forms shall be kept in the client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request, according to Section 8.509.31.G, or if requested by the state for monitoring purposes.

F. COST CONTAINMENT

The case manager shall determine whether the person can be served at or under the cost containment criteria of Section 8.509.14(l) for long term care services for an individual recipient by using a state-prescribed Prior Authorization Request (PAR) form to:

- 1. Determine the maximum authorized costs for all HCBS-CMHS services for the period of time covered by the case plan and compute the average cost per day by dividing by the number of days in the case plan period; and
- 2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:
 - a. Enter (in the designated space on the PAR form) the average monthly cost of nursing facility care; and
 - b. Subtract from that amount the client's gross monthly income; and
 - c. Subtract from that amount the client's Home Care Allowance grant amount, if any; and
 - d. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount which cannot be exceeded for the cost of HCBS services.

3. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.

G. PRIOR AUTHORIZATION REQUESTS

1. The case manager shall submit prior authorization requests (PARs) for all HCBS-CMHS services to the state or its agent in a timely manner in accordance with the STATE PRIOR AUTHORIZATION OF SERVICES in Section 8.485.90.
2. Every PAR shall include the Long Term Service Plan form; the Prior Approval Request form; the Uniform Long Term Care Client Assessment (ULTC-100.2) form; and written documentation, from the income maintenance technician or the eligibility system, of the client's current monthly income. All units of service requested on the Prior Approval Request form must be listed on the Long Term Service Plan form. If a range of units is estimated on the Long Term Service plan, the number of units at the higher end of the range may be requested on the Prior Approval Request form. "PRN" services must be given a numerical estimate on the Long Term Care plan.
3. If a PAR is for a new admission, or a re-admission, the Intake form shall be included with the PAR.
4. If a PAR includes a request for home modification services, the PAR shall also include all documentation listed at Section 8.493, HOME MODIFICATION.
5. If a PAR is for an Alternative Care Facility client who is 300% eligible, the most recent state-prescribed Client Payment form shall be included in the PAR. All medical and remedial care requested as deductions on the Client Payment form must be listed on the LONG TERM Service Plan form.
6. The start date on the prior authorization request form shall never precede the start date of eligibility for HCBS-CMHS services, according to Section 8.509.16, START DATE.
7. The PAR shall not cover a period of time longer than the length of stay assigned by the URC.
8. A PAR does not have to be submitted for a non-diversion, as defined at 8.509.14(O).
9. If a PAR is returned to the case management agency for corrections, the corrected PAR must be returned to the State or its agent within thirty (30) calendar days after the case management agency receives the "Return to Provider" letter.

H. CASE MANAGEMENT AGENCY RESPONSIBILITY

1. The case management agency shall be financially responsible for any services which it authorized to be provided to the client, or which continue to be rendered by a provider due to the case management agency's failure to timely notify the provider that the client was no longer eligible for services, which did not receive approval by the state or its agent.

8.509.32 ONGOING HCBS-CMHS CLIENTS

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS clients shall be in accordance with ON-GOING CASE MANAGEMENT in Section 8.393.24. In addition, the case manager shall:
 - a. Contact each client quarterly, or more frequently, as determined by the client's assessed needs. Contact may be at the client's place of residence, by telephone, or other appropriate setting as determined by the client's needs.
 - b. Review the ULTC.100.2 and the Service Plan with the client every six (6) months on a face-to-face basis.
2. The case manager shall refer the client for mental health services taking into account client choice. The case manager shall coordinate case management activities for those clients who are receiving mental health services from the Behavioral Health Organizations (BHO).
3. On-going case management shall include, but not be limited to the following tasks:
 - a. Review of the client's case plan and service agreements;
 - b. Contact with the client concerning whether services are being delivered according to the plan; and the client's satisfaction with services provided;
 - c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;
 - d. Contact with appropriate parties in the event any issues or complaints have been presented by the client or others;
 - e. Conflict resolution and/or crisis intervention, as needed;
 - f. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;
 - g. Notification of appropriate enforcement agencies, as needed; and
 - h. Referral to community resources, and arrangement for non-HCBS-CMHS services, as needed.
4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.
5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or mis-utilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

B. REVISIONS

1. SERVICES ADDED TO THE SERVICE PLAN

- a. Whenever a change in the service plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the state or its agent.
 - 1) The revision PAR shall include the revised Long Term Care plan form and the revised Prior Authorization Request form.
 - 2) The revised service plan form shall list the services being revised and shall state the reason for the revision. Services on the revised service plan form, plus all services on the original service plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.
 - 3) The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.
- b. If a revised PAR includes a new request for home modification services, the revised PAR shall also include all documentation listed at Section 8.493.

2. SERVICES DECREASED ON THE SERVICE PLAN

- a. A revised PAR does not need to be submitted if services on the service plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness
- b. If services are decreased without the client's agreement according to Section 8.057.5, the case manager shall notify the client of the adverse action and of appeal rights, according to Section 8.057, et. seq.

C. REASSESSMENT

- 1. The case manager shall complete a reassessment of each HCBS-CMHS client before the end of the length of stay assigned by the URC at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect HCBS-CMHS eligibility.
- 2. The case manager shall complete the reassessment, utilizing the Uniform Long Term Care Client Assessment Instrument (ULTC 100.2).
- 3. Reassessment shall include, but not be limited to, the following activities:
 - a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long term care benefits;
 - b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;
 - c. Evaluate continuing need for the HCBS-CMHS program, and clearly document reasons for continuing HCBS; or terminate the client's eligibility according to Section 8.509.32(E);

- d. Ensure that all information needed from the medical provider for the URC level of care review is included on the ULTC 100.2 form;
- e. Reassess the client's functional status, according to the procedures in Section 8.509.31(B);
- f. Review the case plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.509.31(D);
- g. Refer the client to community resources as needed;
- h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31(G). For clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ULTC 100.2. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Office of Administrative Courts to the client; or (c) a copy of the notice of a scheduled court date.

Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be accepted as a substitute for the approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

D. TRANSFER PROCEDURES

- 1. When clients move, cases shall be transferred according to the current statewide Mental Health Services Continuity of Care Policy.
- 2. INTERCOUNTY TRANSFERS shall be in accordance with Section 8.393.31.
- 3. INTERDISTRICT TRANSFERS shall be in accordance with Section 8.393.32.

E. TERMINATION

- 1. Clients shall be terminated from the HCBS-CMHS program whenever they no longer meet one or more of the eligibility requirements at Section 8.509.15. Clients shall also be terminated from the program if they die, move out of state or voluntarily withdraw from the program.
- 2. Clients who are terminated from HCBS-CMHS because they no longer meet one or more of the eligibility requirements at Section 8.509.15 shall be notified of the termination and their appeal rights as follows:
 - a. Financial Eligibility

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason.

- b. Level of Care AND Target Group

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason.
 - c. Receiving Services

Procedures at Section 8.509.31, (C), shall be followed for terminations for this reason
 - d. Institutional Status

Procedures at Section 8.509.31(C), shall be followed for terminations for this reason. In the case of termination for extended hospitalization, the case manager shall send the termination notice on the thirtieth (30) day of hospitalization. The termination shall be effective at the end of the advance notice period. If the client returns home before the end of the advance notice period, the termination shall be rescinded.
 - e. Cost-effectiveness

Procedures at Section 8.509.31(C), shall be followed for terminations for this reason.
3. When clients are terminated from HCBS-CMHS for reasons not related to me eligibility requirements at Section 8.509.31(C), the case manager shall follow the procedures below:
- a. Death

Clients who die shall be terminated from the HCBS-CMHS program, effective upon the day after the date of death.
 - b. Moved out of State

Clients who move out of Colorado shall be terminated from the HCBS-CMHS program, effective upon the day after the date of the move. The case manager shall send the client a state-prescribed Advisement Letter advising the client that the case has been closed. Clients who leave the state on a temporary basis, with intent to return to Colorado, according to the Income Maintenance Staff Manual Section 1140.2, shall not be terminated from the HCBS-CMHS program unless one or more of the other eligibility criteria, as specified at Section 8.509.15 is no longer met.
 - c. Voluntary Withdrawal from the Program

Clients who voluntarily withdraw from the HCBS-CMHS program shall be terminated from the program, effective upon the day after the date on which the client either requests in writing to withdraw from the program, or the date on which the client enters a nursing facility. The case manager shall send the client a state-prescribed Advisement Letter advising the client that the case has been closed.
4. The case manager shall provide appropriate referrals to other community resources, as needed, upon termination.

5. The case manager shall immediately notify all providers on the case plan of any terminations.
6. If a case is terminated before an approved PAR has expired, the case manager shall submit, to the state or its agent, a copy of the current prior authorization request form, on which the end date is adjusted (and highlighted in some manner on the form); and the reason for termination shall be written on the form.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the income maintenance technician of any and all changes in the client's participation in HCBS-CMHS, and shall provide the technician with copies of the first page of all URC-approved ULTC-100.2 forms.
2. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current state-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.
3. If the client has an open service case file at the county department of social services, the case manager shall keep the client's caseworker informed of the client's status and shall participate in mutual staffing of the client's case.
4. The case manager shall inform the client's physician of any significant changes in the client's condition or needs.
5. Within five (5) working days of receipt, from the State or its agent, of the approved Prior Authorization Request form, the case manager shall provide copies to all the HCBS-CMHS providers in the case plan.
6. The case manager shall notify the URC, on a form prescribed by the state of the outcome of all non-diversions, as defined at Section 8.509.14.
7. The case manager shall report to the Colorado Department of Public Health and Environment any congregate facility which is not licensed.
8. The case management agency shall notify the state of any client appeals which are initiated as a result of denials or terminations made by the case management agency.

B. CASE RECORDING/DOCUMENTATION

1. The case management agency shall maintain records on every individual for whom intake was conducted, including a copy of the intake form. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the case management agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.
2. The case record shall include:
 - a. Identifying information, including the state identification (Medicaid) number, and

- b. All state-required forms; and
 - c. Documentation of all case management activity required by these regulations.
- 3. Case management documentation shall meet all the following standards:
 - a. A separate case record shall be maintained for each client receiving services in the Home and Community Based Services for Community Mental Health Supports Program.
 - b. Documentation shall be legible;
 - c. Entries shall be written at the time of the activity or shortly thereafter,
 - d. Entries shall be dated according to the date of the activity, including the year;
 - e. Entries shall be made in permanent ink;
 - f. The client shall be identified on every page;
 - g. The person making each entry shall be identified;
 - h. Entries shall be concise, but shall include all pertinent information;
 - i. All information regarding a client shall be kept together for easy access and review by case managers, supervisors, program monitors and auditors;
 - j. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact, or is a judgment or conclusion on the part of anyone;
 - k. All persons and agencies referenced in the documentation shall be identified by name and by relationship to the client;
 - l. All forms prescribed by the State shall be filled out by the case manager to be complete, correct and accurate.
- 4. All records shall be kept for the period of time specified in the case management agency contract, and shall be made available to the state as specified in the contract.

8.509.40 HCBS-CMHS PROVIDERS

- A. Any provider agency with a valid contract to provide HCBS-EBD services, according to Section 8.487, shall be deemed certified to provide the same services to HCBS-CMHS clients.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

Adaptive Equipment means a device(s) that is used to assist with completing activities of daily living.

Allocation means the funds determined by the case manager and made available by the Department to clients receiving Consumer Directed Attendant Support Services (CDASS) and administered by the Financial Management Services (FMS) authorized for attendant support services and administrative fees paid to the FMS.

Attendant means the individual who meets qualifications in 10 CCR 2505-10, § 8.510.8 who provides CDASS as determined by 10 CCR 2505-10, § 8.510.3 and is hired by the client or by a contracted FMS vendor.

Attendant Support Management Plan (ASMP) means the documented plan for clients to manage their care as determined by 10 CCR 2505-10, § 8.510.4 which is reviewed and approved by the Case Manager.

Authorized Representative (AR) means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to direct CDASS on a client's behalf and meets the qualifications as defined at 10 CCR 2505-10, § 8.510.6 and § 8.510.7.

Benefits Utilization System (BUS) means the web based data system maintained by the Department for recording case management activities associated with Long Term Services and Supports (LTSS).

Case Management Agency (CMA) means a Department approved agency within a designated service area where an applicant or client can obtain Long Term Services and Supports case management services.

Case Manager means an individual who meets the qualifications to perform case management activities by contract with the Department.

Consumer Directed Attendant Support Services (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care, and homemaker activities.

CDASS Training means the required training, including a final, comprehensive assessment, provided by the Department or its designee to a client/AR who is interested in CDASS.

Continued Stay Review (CSR) means a periodic face to face review of a client's condition and service needs by a Case Manager to determine a client's continued eligibility for Long Term Services and Supports in the client's residence.

Cost Containment means the cost of providing care in the community is less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services.

Department means the Department of Health Care Policy and Financing.

Eligibility means a client qualifies for Medicaid based on the applicable eligibility category and the client's individual financial circumstances, including, but not limited to, income and resources.

Financial Management Services (FMS) means an entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual client allocations for CDASS.

Fiscal/Employer Agent (F/EA) is an FMS model where the FMS is an agent of the client as the employer. The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative. The F/EA pays workers and vendors on the participant's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both employer and employee Social Security and Medicare Taxes.

Functional Eligibility means an applicant or client meets the criteria for Long Term Services and Supports as determined by the Department's prescribed instrument as defined in 10 CCR 2505-10, § 8.401.

Functional Needs Assessment means a component of the Assessment process which includes a comprehensive evaluation using the ULTC (Uniform Long Term Care) Instrument to determine if the client meets the appropriate Level of Care (LOC).

Home and Community Based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to clients in community settings. These services are designed to help older persons and persons with disabilities remain living at home.

Inappropriate Behavior means offensive behavior which includes: documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language over a period of time.

Licensed Medical Professional means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses: physician, physician assistant and nurse governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

Long Term Services and Supports (LTSS) means Nursing Facilities, Intermediate Care Facilities for the Intellectually/Developmentally Disabled (ICF/IDD), Home and Community Based Services (HCBS), Long Term Home Health or the Program of All-inclusive Care for the Elderly (PACE), Swing Bed and Hospital Back Up Program (HBU).

Long Term Services and Supports Certification Period means the designated period of time in which a client is functionally eligible to receive Long Term Services and Supports not to exceed one year.

Prior Authorization Request (PAR) means the Department prescribed form that assures the provider that the service is medically necessary and a Colorado Medical Assistance Program benefit.

Notification means the routine methods in which the Department or its designee conveys information about CDASS. Methods include but are not limited to the CDASS web site, client statements, Case Manager contact, or FMS contact.

Reassessment means a review of the Assessment, to determine and document a change in the client's condition and/or client's service needs.

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

Training and Operations Vendor means the organization contracted by the Department to provide training to CDASS Clients/authorized representatives, provide training to case managers on participant direction, and provide customer service related to participant direction.

8.510.2 ELIGIBILITY

8.510.2.A. To be eligible for CDASS, an individual shall meet all of the following:

1. Choose the CDASS service delivery option
2. Meet medical assistance Financial Eligibility requirements
3. Meet Long Term Services and Supports Functional Eligibility requirements
4. Be eligible for an HCBS Waiver with the CDASS option
5. Demonstrate a current need for Attendant support

6. Document a pattern of stable health that necessitates a predictable pattern of Attendant support and appropriateness of CDASS services
7. Provide a statement from the primary care physician attesting to the client's ability to direct his or her care with sound judgment or a required AR with the ability to direct the care on the client's behalf
8. Complete all aspects of the ASMP and training and demonstrate the ability to direct care or have care directed by an AR

8.510.3 CDASS SERVICES

8.510.3.A Covered services shall be for the benefit of only the client and not for the benefit of other persons living in the home.

8.510.3.B Services include:

1. Homemaker. General household activities provided by an Attendant in a client's home to maintain a healthy and safe environment for the client. Homemaker activities shall be applied only to the permanent living space of the client and multiple attendants may not be reimbursed for duplicating household tasks. Tasks may include the following activities or teaching the following activities:
 - a. Routine light housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas
 - b. Meal preparation
 - c. Dishwashing
 - d. Bed making
 - e. Laundry
 - f. Shopping for necessary items to meet basic household needs
2. Personal care. Services furnished to an eligible client in the community or in the client's home to meet the client's physical, maintenance, and supportive needs. Including:
 - a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as forks, knives, and straws
 - b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling the distilled water reservoir, and moving the cannula or mask from the client's face
 - c. Skin care preventative in nature when skin is unbroken; including the application of non-medicated/non-prescription lotions and/or sprays and solutions, rubbing of reddened areas, and routine foot checks for people with diabetes
 - d. Bladder/Bowel Care:
 - i) Assisting client to and from the bathroom
 - ii) Assistance with bed pans, urinals, and commodes

- iii) Changing of incontinence clothing or pads
 - iv) Emptying Foley or suprapubic catheter bags only if there is no disruption of the closed system
 - v) Emptying ostomy bags
- e. Personal hygiene:
 - i) Bathing including washing, shampooing, and shaving
 - ii) Grooming
 - iii) Combing and styling of hair
 - iv) Trimming, cutting, and soaking of nails
 - v) Basic oral hygiene and denture care
- f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings and application of orthopedic devices such as splints and braces or artificial limbs
- g. Transferring a client when the client has sufficient balance and strength to assist with and can direct the transfer
- h. Assistance with mobility
- i. Positioning when the client is able to verbally or non-verbally identify when the position needs to be changed including simple alignment in a bed, wheelchair or other furniture
- j. Assistance with self administered medications when the medications have been preselected by the client, a family member, a nurse or a pharmacist and are stored in containers other than the prescription bottles, such as medication minders and medication reminding:
 - i) Medication minders must be clearly marked as to the day and time of dosage and must be kept in a way as to prevent tampering
 - ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable
- k. Cleaning and basic maintenance of durable medical equipment
- l. Protective oversight when the client requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property

- m. Accompanying includes going with the client, as necessary on the care plan, to medical appointments, and errands such as banking and household shopping. Accompanying the client to provide one or more personal care services as needed during the trip. Companionship is not a benefit of CDASS
- 3. Health Maintenance Activities. Routine and repetitive health related tasks furnished to an eligible client in the community or in the client's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include:
 - a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional
 - b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation
 - c. Mouth care performed when:
 - i) there is injury or disease of the face, mouth, head or neck
 - ii) in the presence of communicable disease
 - iii) the client is unconscious
 - iv) oral suctioning is required
 - d. Dressing including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary
 - e. Feeding:
 - i) When oral suctioning is needed on a stand-by or other basis
 - ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study
 - iii) Syringe feeding
 - iv) Feeding using apparatus
 - f. Exercise prescribed by a licensed medical professional including passive range of motion
 - g. Transferring a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed
 - h. Bowel care provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist

- i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters
- j. Medical management required by a medical professional to monitor: blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections
- k. Respiratory care:
 - i) Postural drainage
 - ii) Cupping
 - iii) Adjusting oxygen flow within established parameters
 - iv) Suctioning of mouth and nose
 - v) Nebulizers
 - vi) Ventilator and tracheostomy care
 - vii) Prescribed respiratory equipment

8.510.4 ATTENDANT SUPPORT MANAGEMENT PLAN

8.510.4.A The client/AR shall develop a written ASMP which shall be reviewed by the Training and Operations Vendor and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date to the FMS. The ASMP is required by the FMS following initial training and shall be modified when there is a change in the client's needs. The plan shall describe the individual's:

- 1. Current health status
- 2. Needs and requirements for CDASS
- 3. Plans for securing CDASS
- 4. Plans for handling emergencies
- 5. Assurances and plans regarding direction of CDASS Services, as described at 10 CCR 2505 -10, § 8.510.3 and § 8.510.6 if applicable
- 6. Plans for management of the budget within the client's Individual Allocation
- 7. Designation of an Authorized Representative
- 8. Designation of regular and back-up employees approved for hire

8.510.4.B. If ASMP is disapproved by the Case Manager, the client has the right to review that disapproval. The client shall submit a written request to the CMA stating the reason for the review and justification of the proposed ASMP. The client's most recently approved ASMP shall remain in effect while the review is in process.

8.510.5 TRAINING ACTIVITIES

8.510.5.A. When necessary to obtain the goals of the ASMP, the client/AR shall verify that each attendant has been or will be trained in all necessary health maintenance activities prior to performance by the attendant.

8.510.5.B The verification requirement of 10 CCR 2505-10, §8.510.5.A above will be on a form provided by the FMS and returned to the FMS with the client/AR completed employment packet.

8.510.6 CLIENT/AR RESPONSIBILITIES

8.510.6.A. Client/AR responsibilities for CDASS Management:

1. Attend training provided by the Training and Operations Vendor; clients who cannot attend training shall designate an AR
2. Develop an ASMP
3. Determine wages for each Attendant not to exceed the rate established by the Department. Wages shall be established in accordance with Colorado Department of Labor and Employment standards including, but not limited to, minimum wage and overtime requirements.
4. Determine the required credentials for Attendants
5. Complete previous employment reference checks on Attendants
6. Follow all relevant laws and regulations applicable to client's supervision of Attendants
7. Explain the role of the FMS to the Attendant
8. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation
9. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and client/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS services
10. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement
11. Authorize the FMS to make any changes in the Attendant wages
12. Understand that misrepresentation or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. Client/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS
13. Completing and managing all paperwork and maintaining employment records
14. Select an FMS vendor upon enrollment into CDASS.

8.510.6.B. Client/AR responsibilities for CDASS in the F/EA FMS model:

1. Recruit, hire, fire and manage Attendants

2. Train Attendants to meet client needs
3. Terminate Attendants who are not meeting client needs
4. Operate as the sole employer of the attendant
5. Complete necessary employment related functions through the FMS agent, including hiring and termination of Attendants and employer related paperwork necessary to obtain an employer tax ID

8.510.6.C Client/AR responsibilities for Verification:

1. Sign and return a responsibilities acknowledgement form for activities listed in 10 CCR 2505-10, §8.510.6 to the Case Manager.

8.510.6.D. Clients receiving CDASS services have the following Rights:

1. Right to receive instruction on managing CDASS.
2. Right to receive program materials in accessible format.
3. Right to receive notification of changes to CDASS.
4. Right to participate in Department sponsored opportunities for input.
5. CDASS clients have the right to transition back to Personal Care, Homemaker, and Home Health Aide and Nursing services provided by an agency at any time. A client who wishes to transition back to an agency-provided services shall contact the Case Manager. The Case Manager shall coordinate arrangements for the services.
6. A client/AR may request a re-assessment, as described at 10 CCR 2505-10, § 8.390.1 (N), if his or her level of service needs have changed.
7. A client/AR may revise the ASMP at any time with CM approval. CM shall notify FMS of changes.

8.510.7 AUTHORIZED REPRESENTATIVES

8.510.7.A. CDASS clients who require an AR may not serve as an AR for another CDASS client.

8.510.7.B. Authorized Representatives shall not receive reimbursement for AR services and shall not be reimbursed for CDASS services as an Attendant for the client they represent.

8.510.8 ATTENDANTS

8.510.8.A. Attendants shall be at least 18 years of age and demonstrate competency in caring for the client to the satisfaction of the client/AR.

8.510.8.B. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more clients collectively.

8.510.8.C. Authorized Representatives shall not be employed as an Attendant for the client.

- 8.510.8.D. Attendants must be able to perform the tasks on the Service Plan they are being reimbursed for and the client must have adequate Attendants to assure compliance with all tasks on the service plan.
- 8.510.8.E. Attendants shall not 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.
- 8.510.8.F. Attendants shall not have had his or her license as a nurse or certification as a nurse aide suspended or revoked or his application for such license or certification denied.
- 8.510.8.G. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the client/AR not to exceed the amount established by the Department. The FMS shall make all payments from the client's Individual Allocation under the direction of the client/AR within the limits established by the Department.
- 8.510.8.H. Attendants may not attend training provided by the Training and Operations Vendor during instruction.

8.510.85 FINANCIAL MANAGEMENT SERVICES

- 8.510.85.A The FMS vendor shall be responsible for the following tasks:
1. Collect and process timesheets submitted by attendants.
 2. Conduct payroll functions including withholding employment related taxes such as worker's compensation insurance, unemployment compensation insurance, withholding of all federal and state taxes, compliance with federal and state laws regarding overtime pay and minimum wage requirements.
 3. Distribute paychecks in accordance with timelines established by the Colorado Department of Labor and Employment.
 4. Submit authorized claims for CDASS provided to eligible client.
 5. Verify Attendants' citizenship status and maintain copies of the I-9 documents.
 6. Track and report utilization of client allocations.
 7. Comply with Department regulations at 10 CCR 2505-10 and the contract with the Department.
 8. Maintain system prompts in the FMS vendor portal requiring case managers to verify all requirements and forms have been completed prior to completing a prior authorization request for services.
 9. Comply with all requirements set forth by the Affordable Care Act

8.510.85.B In addition to the requirements set forth at 10 CCR 2505-10, §8.510.9.A, the FMS vendor operating under the F/EA model shall be responsible for obtaining designation as a Fiscal/Employer Agent per Section 3504 of the IRS Code. This statute is hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.510.86 SELECTION OF FMS VENDORS

8.510.86.A The client/AR shall select an FMS vendor at the time of enrollment into CDASS from the vendors contracted with the Department.

8.510.86.B The client/AR shall remain with the selected FMS vendor until the selection of FMS is changed during the designated open enrollment period.

8.510.9 START OF SERVICES

8.510.9.A. The start date shall not occur until all of the requirements defined at 10 C.C.R. 2505-10, § 8.510.2, 8.510.4, 8.510.5, 8.510.6 and 8.510.8 have been met.

8.510.9.B. The Case Manager shall approve the ASMP, establish a certification period, submit a PAR and receive a PAR approval before a client is given the start date and can begin CDASS.

8.510.9.C. The FMS shall process the Attendant's employment packet within the Department's prescribed timeframe and ensure the client has a minimum of two approved Attendants prior to starting CDASS. Employment relationships with two Attendants must be maintained while participating in CDASS.

8.510.9.D. The FMS will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS provides the client/AR with an employee number and confirms employment status.

8.510.9.E. If a client is transitioning from a Hospital, Nursing Facility, or HCBS agency services the CM shall coordinate with the Discharge Coordinator to ensure the discharge date and CDASS start date correspond.

8.510.10 SERVICE SUBSTITUTION

8.510.10.A. Once a start date has been established for CDASS, the Case Manager shall establish an end date and disenroll the individual from any other Medicaid-funded Attendant support including home health effective as of the start date of CDASS.

8.510.10.B. Case Managers shall not authorize, on the PAR, concurrent payments for CDASS and other waiver service delivery options for Personal Care services, Homemaker services, and Health Maintenance Activities for the same individual.

8.510.10.C. Clients may receive up to sixty days of Medicaid acute home health agency based services directly following acute episodes as defined by 10 CCR 2505-10, § 8.523.11.K.1. Client allocations shall not be changed for sixty days in response to an acute episode unless acute home health services are unavailable. If acute home health is unavailable, a client's allocation may be temporarily adjusted to meet a client's need.

8.510.10.D. Clients may receive Hospice services in conjunction with CDASS services. CDASS service plans shall be modified to ensure no duplication of services.

8.510.11 ENDING CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.11.A. If an individual chooses to use an alternate care option, an institutional setting, or is terminated involuntarily, a client will be terminated from CDASS when the Case Manager has secured an adequate alternative to CDASS in the community.

8.510.11.B. Prior to a client being terminated for reasons other than those listed in section 10 CCR 2505-10, §8.510.13, the following steps may be taken:

1. Mandatory re-training conducted by the contracted Training and Operations Vendor
2. Required designation of an AR if one is not in place, or mandatory re-designation of an AR if one has already been assigned
3. Discontinuation according to the following:
 - i) The notice shall provide the client/AR with the reasons for termination and with information about the client's rights to fair hearing and appeal procedures, in accordance with 10 CCR 2505-10, §§ 8.057. Once notice has been given for termination, the client/AR shall contact the Case Manager for assistance in obtaining other home care services. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS services and begin alternate care services. Exceptions may be made to the thirty (30) day advance notice requirement when the Department has documented that there is danger to the client or to the Attendant(s). The Case Manager shall notify the FMS of the date on which the client is being terminated from CDASS.

8.510.12 TERMINATION

8.510.12.A. Clients may be terminated for the following reasons:

1. The client/AR fails to comply with CDASS program requirements
2. The client/AR demonstrates an inability to manage Attendant support
3. A client/AR no longer meets program criteria due to deterioration in physical or cognitive health
4. The client/AR spends the monthly Allocation in a manner indicating premature depletion of funds
5. The client's medical condition causes an unsafe situation for the client, as determined by the treating physician
6. The client provides false information or false records as determined by the Department

8.510.12.B. Clients who are terminated according to 10 CCR 2505-10, § 8.510.12 may be re-enrolled for future CDASS service delivery

8.510.13 INVOLUNTARY TERMINATION

8.510.13.A. Clients may be involuntarily terminated for the following reasons:

1. A client/AR no longer meets program criteria due to deterioration in physical or cognitive health AND refuses to designate an AR to direct services
 2. The client/AR demonstrates a consistent pattern of overspending their monthly Allocation leading to the premature depletion of funds AND the Department has determined that adequate attempts to assist the client/AR to resolve the overspending have failed
 3. The client/AR exhibits Inappropriate Behavior toward Attendants, Case Managers, the Training and Operations Vendor or the FMS, and the Department has determined that the Training and Operations Vendor has made adequate attempts to assist the client/AR to resolve the Inappropriate Behavior, and those attempts have failed
 4. Documented misuse of the monthly Allocation by client/AR has occurred
 5. Intentional submission of fraudulent CDASS documents to Case Managers, the Training and Operations Vendor, the Department or the FMS
 6. Instances of convicted fraud and/or abuse
- 8.510.13.B. Termination may be initiated immediately for clients being involuntarily terminated
- 8.510.13.C. Clients who are involuntarily terminated according to 10 CCR 2505-10, § 8.510.13 may not be re-enrolled in CDASS as a service delivery option.

8.510.14 CASE MANAGEMENT FUNCTIONS

- 8.510.14.A. The Case Manager shall review and approve the ASMP completed by the client/AR. The Case Manager shall notify the client/AR of the approval and establish a certification period and Allocation.
- 8.510.14.B. If the Case Manager determines that the ASMP is inadequate to meet the client's CDASS needs, the Case Manager shall assist the client/AR with further development of the ASMP.
- 8.510.14.C. The Case Manager shall calculate the Individual Allocation for each client who chooses CDASS as follows:
1. Calculate the number of Personal Care, Homemaker, and Health Maintenance Activities hours needed on a monthly basis using the Department prescribed method. The needs determined for the Allocation should reflect the needs in the ULTC assessment tool and the service plan. The Case Manager shall use the Departments established rate for Personal Care, Homemaker, and Health Maintenance Activities to determine the client's Allocation.
 2. The Allocation should be determined using the Department prescribed method at the initial enrollment and at CSR, and should always match the client's need for services.
- 8.510.14.D. Prior to training or when an allocation changes, the Case Manager shall provide written notification of the Individual Allocation to each client.
- 8.510.14.E. A client/AR who believes he or she needs a change in Attendant support, may request the Case Manager to perform a reassessment. If the reassessment indicates that a change in Attendant support is justified, the client/AR shall amend ASMP and the Case Manager shall complete a PAR revision indicating the increase and submit it to the Department's fiscal agent. The Case Manager shall provide notice of the change to client/AR and make changes in the BUS.

- 8.510.14.F. In approving an increase in the individual Allocation, the Case Manager shall consider all of the following:
1. Any deterioration in the client's functioning or change in the natural support condition
 2. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services
 3. The appropriate use and application of funds to CDASS services
- 8.510.14.G. In reducing an Individual Allocation, the Case Manager shall consider:
1. Improvement of functional condition or changes in the available natural supports
 2. Inaccuracies or misrepresentation in previously reported condition or need for service
 3. The appropriate use and application of funds to CDASS services
- 8.510.14.H. Case Managers shall notify the state fiscal agent to cease payments for all existing Medicaid-funded Personal Care, Homemaker, Health Maintenance Activities and/or Long Term Home Health as defined under the Home Health Program at 10 CCR 2505-10, §8.520 et seq. as of the client's CDASS start date.
- 8.510.14.I. For effective coordination, monitoring and evaluation of clients receiving CDASS, the Case Manager shall:
1. Contact the CDASS client/AR once a month during the first three months to assess their CDASS management, their satisfaction with care providers and the quality of services received. Case Managers may refer clients to the FMS for assistance with payroll and budgeting and to the Training and Operations Vendor for training needs and supports
 2. Contact the client quarterly, after the first three months to assess their implementation of service plans, CDASS management issues, and quality of care, CDASS expenditures and general satisfaction
 3. Contact the client/AR when a change in AR occurs and contact the client/AR once a month for three months after the change takes place
 4. Review monthly FMS reports to monitor client spending patterns and service utilization to ensure appropriate budgeting and follow up with the client/AR when discrepancies occur
 5. Utilize Department overspending protocol when needed to assist clients
- 8.510.14.J. Reassessment: For clients receiving CDASS, the Case Manager shall conduct an interview with each client/AR every six months and at least every 12 months, the Interview shall be conducted face to face. The interview shall include review of the ASMP and documentation from the physician stating the client/AR's ability to direct care.

8.510.15 ATTENDANT REIMBURSEMENT

- 8.510.15.A. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the client/AR hiring the Attendant. The FMS shall make all payments from the client's Individual Allocation under the direction of the client/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified on the ASMP.

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

8.510.15.C. Allocations shall not exceed the monthly cost containment cap. The Department may approve an over cost containment Allocation if it meets prescribed Department criteria.

8.510.16 REIMBURSEMENT TO FAMILY MEMBERS

8.510.16.A. Family members/legal guardians may be employed by the client or FMS to provide CDASS, subject to the conditions below. For the purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption, or common law.

8.510.16.B. The family member or legal guardian shall be employed by the client or FMS and be supervised by the client/AR if providing CDASS.

8.510.16.C. The family member and/ or legal guardian being reimbursed as a Personal Care, Homemaker, and/or Health Maintenance Activities Attendant shall be reimbursed at an hourly rate with the following restrictions:

1. A family member and/or legal guardian shall not be reimbursed for more than forty (40) hours of CDASS in a seven day period from 12:00am on Sunday to 11:59pm on Saturday.
2. Family member wages shall be commensurate with the level of skill required for the task and should not deviate greatly from that of a non-family member Attendant unless there is evidence of a higher level of skill.
3. A member of the client's household may only be paid to furnish extraordinary care as determined by the Case Manager. Extraordinary care is determined by assessing whether the care to be provided exceeds the range of care that a family member would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the client and avoid institutionalization. Extraordinary care shall be documented on the service plan.

8.510.16.D. A client/AR who choose a family member as a care provider, shall document the choice on the Attendant Support Services management plan.

8.515 HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH BRAIN INJURY (HCBS-BI)

8.515.1 LEGAL BASIS

The Home and Community-Based Services for Persons with Brain Injury (HCBS-BI) program is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a (2011). This waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n (2011). 42 U.S.C. §§ 1396a and 1396n are incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material.

This regulation is adopted pursuant to the authority in Section 25.5-1-303, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Sections 24-4-101 et seq., C.R.S. and the Home and Community-Based Services for Persons with Brain Injury Act, Sections 25.5-6-701 et seq., C.R.S.

Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO 80203. Additionally, any incorporated material in these rules may be examined at any State depository library.

8.515.2 DEFINITIONS OF SERVICES PROVIDED

Adult Day Services means services as defined at Section 8.515.70

Behavioral Programming and Education means services as defined at Section 8.516.40.

Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510

Counseling Services means services as defined at Section 8.516.50.

Day Treatment means services as defined at Section 8.515.80.

Electronic Monitoring Services means services as defined at Section 8.488.

Home Modification means services as defined at Section 8.493.

Independent Living Skills Training (ILST) means services as defined at Section 8.516.10.

Non-Medical Transportation Services means services as defined at Section 8.494.

Personal Care means services as defined at Section 8.489.

Respite Care means services as defined at Section 8.516.70.

Specialized Medical Equipment and Supplies means services as defined at Section 8.515.50.

Substance Abuse Counseling means services as defined at Section 8.516.60.

Supported Living means services delivered by a community-based residential program that has been certified by the Department to provide the services defined at Section 25.5-6-703(8), C.R.S.

Transitional Living Program means services as defined at Section 8.516.30.

8.515.3 GENERAL DEFINITIONS

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

1. Nonpsychotic mental disorders due to brain damage; or
2. Anoxic brain damage; or
3. Compression of the brain; or
4. Toxic encephalopathy; or
5. Subarachnoid and/or intracerebral hemorrhage; or
6. Occlusion and stenosis of precerebral arteries; or
7. Acute, but ill-defined cerebrovascular disease; or
8. Other and ill-defined cerebrovascular disease; or
9. Late effects of cerebrovascular disease; or
10. Fracture of the skull or face; or
11. Concussion resulting in an ongoing need for assistance with activities of daily living; or
12. Cerebral laceration and contusion; or
13. Subarachnoid, subdural, and extradural hemorrhage, following injury; or
14. Other unspecified intracranial hemorrhage following injury; or
15. Intracranial injury; or
16. Late effects of musculoskeletal and connective tissue injuries; or
17. Late effects of injuries to the nervous system; or
18. Unspecified injuries to the head resulting in ongoing need for assistance with activities of daily living.

Case Management Agency means the agency designated by the Department to provide the Single Entry Point Functions detailed at Section 8.393.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Service Plan means the plan developed by the case manager in coordination with the HCBS-BI client and/or the legal guardian to identify and document the HCBS-BI services, other Medicaid services, and any other non-Medicaid services or supports that the HCBS-BI client requires in order to live successfully in the community.

8.515.4 SCOPE AND PURPOSE

The HCBS-BI program provides those services listed at Section 8.515.2 to eligible individuals with brain injury that require long term supports and services in order to remain in a community-based setting.

8.515.5 ELIGIBLE PERSONS

HCBS-BI program enrollment and services shall be offered only to individuals determined by the Department or its agent to have met all eligibility requirements in this Section 8.515.5.

8.515.5.A LEVEL OF CARE

Eligible individuals shall be determined by the Department or its agent to require one of the following levels of care:

1. Hospital Level of Care as evidenced by:
 - a. The individual shall have been:
 - i. Referred to the Case Management Agency while receiving inpatient care in an acute care or rehabilitation hospital for the treatment of the individual's brain injury; or
 - ii. Determined by the Department or its agent to have a significant functional impairment as evidenced by a comprehensive functional assessment using the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15; and
 - c. The individual shall require goal oriented therapy with medical management by a physician; and
 - d. The individual cannot be therapeutically managed in a community-based setting without significant supervision and structure, specialized therapy, and support services.
2. Nursing Facility Level of Care as evidenced by all of the following:
 - a. The individual shall have been determined by the Department or its agent to have a significant functional impairment as evidenced by a comprehensive functional assessment using the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15;
 - b. The individual shall require long term support services at a level comparable to those services typically provided in a nursing facility.

8.515.5.B TARGET GROUP

Eligible individuals shall be determined by the Department or its agent to meet all of the following target group criteria:

1. The individual shall have a diagnosis of Brain Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) of the ULTC 100.2 assessment tool.

2. Age Limit

- a. Individuals enrolled in the Brain Injury waiver shall be aged 16 years and older and shall have sustained the brain injury prior to the age of 65.

8.515.5.C FINANCIAL ELIGIBILITY

Individuals must meet the financial requirements for long term care medical assistance eligibility specified at Section 8.100.7.

8.515.5.D NEED FOR HCBS-BI SERVICES

- 1. Only clients that currently receive HCBS-BI services, or that have agreed to accept HCBS-BI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-BI program.
 - a. Case management is provided as an administrative function, not an HCBS-BI service, and shall not be used to satisfy this requirement.
 - b. The desire or need for any Medicaid services other than HCBS-BI services, as listed at Section 8.515.1, shall not satisfy this eligibility requirement.
- 2. Clients that have not received an HCBS-BI service for a period greater than 30 consecutive days shall be discontinued from the program.

8.515.5.E EXCLUSIONS FROM ELIGIBILITY

- 1. Individuals who are residents of nursing facilities, hospitals, or other institutional settings are not eligible to receive HCBS-BI services.
- 2. HCBS-BI clients that enter a nursing facility or hospital may not receive HCBS-BI services while admitted to the nursing facility or hospital.
 - a. HCBS-BI clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-BI program.
 - b. HCBS-BI clients entering a nursing facility for Respite Care as an HCBS-BI service shall not be discontinued from the HCBS-BI program.

8.515.5.F COST CONTAINMENT AND SERVICE ADEQUACY OF SERVICES

- 1. The client shall not be eligible for the HCBS-BI program if the case manager determines any of the following during the initial assessment and service planning process:
 - a. The client's needs cannot be met within the Individual Cost Containment Amount.
 - b. The client's needs are more extensive than HCBS-BI program services are able to support and/or that the client's health and safety cannot be assured in a community setting.
- 2. The client shall not be eligible for the HCBS-BI program at reassessment if the case manager determines the client's needs are more extensive than HCBS-BI program services are able to support and/or that the client's health and safety cannot be assured in a community setting.

3. If the case manager determines that the client's needs are more extensive than the HCBS-BI services are able to support and/or that the client's health and safety cannot be assured in a community setting, the case manager must document:
 - a. The results of an Adult Protective Services assessment;
 - b. A statement from the client's physician attesting to the client's mental competency status; and
 - c. Any other documentation necessary to support the determination
4. The client may be eligible for the HCBS-BI program at reassessment if the case manager determines that HCBS-BI program services are able to support the client's needs and the client's health and safety can be assured in a community setting.
 - a. If the case manager expects that the services required to support the client's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the client's request for services is appropriate and justifiable based on the client's condition.
 - i. The client may request of the case manager that existing services remain intact during this review process.
 - ii. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the client with:
 - 1) The client's appeal rights pursuant to Section 8.057; and
 - 2) Alternative options to meet the client's needs that may include, but are not limited to, nursing facility placement.

8.515.6 START DATE FOR SERVICES

- 8.515.6.A. The start date of eligibility for HCBS-BI services shall not precede the date that all of the requirements in Section 8.515.5, have been met. The first date for which HCBS-BI services may be reimbursed shall be the later the following:
1. The date at which financial eligibility is effective.
 2. The date at which the Department or its agent has determined that the client has met all eligibility requirements at Section 8.515.5.
 3. The date at which the client agrees to accept services and signs all necessary intake and service planning forms.
 4. The date of discharge from an institutional setting.

8.515.7 PRIOR AUTHORIZATION OF SERVICES

- 8.515.7.A. All HCBS-BI services must be prior authorized by the Department or its agent.
- 8.515.7.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.
- 8.515.7.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the client's documented medical condition and functional capacity;
2. Reasonable in amount, scope, frequency, and duration;
3. Not duplicative of the other services or supports included in the client's Service Plan;
4. Not for services for which the client is receiving funds to purchase; and
5. Do not total more than 24 hours per day of care.

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

8.515.7.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-BI services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR.

1. Payment for HCBS-BI services is also conditional upon:
 - a. The client's eligibility for HCBS-BI services;
 - b. The provider's certification status; and
 - c. The submission of claims in accordance with proper billing procedures.

8.515.7.F. The prior authorization of services does not constitute an entitlement to those services. All services provided and reimbursed must be delivered in accordance with regulation and be necessary to meet the client's needs.

8.515.7.G. Services requested on the PAR shall be supported by information on the Service Plan and the ULTC-100.2 assessment.

8.515.7.H. The PAR start date shall not precede the start date of HCBS-BI eligibility in accordance with Section 8.515.6.

8.515.7.I. The PAR end date shall not exceed the end date of the HCBS-BI eligibility certification period.

8.515.8 WAITING LIST

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

1. The waiting list shall be maintained by the Department.
2. The date used to establish the person's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.515.5 were determined to have been met and the HCBS-BI Program Administrator was notified.
3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the date of their waiting list placement.

8.515.9 CASE MANAGEMENT FUNCTIONS

The requirements at Section 8.393 shall apply to the Case Management Agencies performing the case management functions of the HCBS-BI program.

8.515.10 PROVIDER AGENCIES

HCBS-BI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

8.515.50 ASSISTIVE AND SPECIAL MEDICAL EQUIPMENT

A. DEFINITIONS

Specialized medical equipment and supplies includes devices controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Assistive Devices include equipment which meets one of the following criteria:

1. Is useful in augmenting an individual's ability to function at a higher level of independence and lessen the number of direct human service hours required to maintain independence;
2. Is necessary to ensure the health, welfare and safety of the individual;
3. Enables the individual to secure help in the event of an emergency;
4. Is used to provide reminders to the individual of medical appointments, treatments, or medication schedules; or
5. Is required because of the individual's illness impairment or disability, as documented on the screening assessment form and the plan of can.

B. INCLUSIONS

1. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.
2. Items which are not of direct medical or remedial benefit to the recipient are excluded.
3. Assistive devices to augment cognitive processes, "cognitive-orthotics" or memory prostheses are included in this service area. Examples of cognitive orthotic devices include informational data bases, spell checkers, text outlining programs, timing devices, security systems, car finders, sounding devices, cuing watches, telememo watches, paging systems, electronic monitoring, tape recorders, electronic checkbooks, electronic medication monitors, and memory telephone.

C. CERTIFICATION REQUIREMENTS

Certification standards refer to both the supplier of equipment as well as the actual product or equipment itself.

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

2. All equipment materials or appliances used as pan of monitoring systems shall carry a UL (Underwriter's Laboratory) number or an equivalent standard.
3. All telecommunications equipment shall be FCC registered.
4. All equipment materials, or appliances shall be installed by properly trained individuals, and the installer shall train the client in the use of the device.
5. All equipment, materials or appliances shall be tested fir proper functioning at the time of installation and at periodic intervals thereafter by a properly trained individual.
6. Any malfunction shall be promptly repaired by a properly trained technician supplied at the provider agency's expense. Equipment shall be replaced when necessary, including buttons and batteries.
7. Assistive equipment providers shall send written information to each clients case manager about the item, how it works, and how it should be maintained.

D. REIMBURSEMENT METHOD FOR ASSISTTVE DEVICES

Reimbursement for assistive devices will be on a per unit basis. If assistive devices are to be used primarily in a vocational application, devices should be funded through the Division of Vocational Rehabilitation with secondary funding from Medicaid.

8.515.70 ADULT DAY SERVICES

A. DEFINITIONS

1. Adult Day Services means both health and social services furnished on a regularly scheduled basis in an adult day services center two or more hours per day, one or more days per week to ensure the optimal functioning of the client Services are directed towards recreation and socialization as well as maintaining a safe and supportive environment.
2. Adult Day Services Center means a non-institutional entity that conforms to requirements for maintenance
3. Maintenance Model means services in health monitoring and individual and group therapeutic and psychological activities which serve as an alternative to long-term nursing home care.
4. Adult day services include:
 - a. Daily monitoring to assure that clients are maintaining personal hygiene and participating in age appropriate social activities as prescribed; and assisting with activities prescribed; and assisting with activities of daily living (e.g., eating, dressing).
 - b. Emergency services including whiten procedures to meet medical crises.
 - c. Assistance in the development of self-care capabilities personal hygiene, and social support services.
 - d. Provision of nutritional needs appropriate to the hours in which the client is served.

- e. Nursing services as necessary to supervise medication regimen of trained medication aides and carry out any of the services listed as SKILLED CARE in SECTION 8.489.30.
- f. Social and recreational services as prescribed to meet the client's needs.
- g. Any additional services if such services are included in the budget submitted to the Department in accordance with the section on REIMBURSEMENT METHOD FOR ADULT DAY CARE below, and determined by the Department to be necessary for adult day care.

B. CERTIFICATION STANDARDS

All adult day service centers shall conform to all of the following Departmental standards

- 1. All providers must conform to all established departmental standards in the general certification standards section.
- 2. All providers of adult service care shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.
- 3. The agency shall provide a clean environment, free of obstacle; that could pose a hazard to client health and safety.
- 4. Agencies shall provide lockers or a safe place for clients' personal items.
- 5. Adult day service centers shall provide recreational areas and activities appropriate to the number and needs of the recipients.
- 6. Drinking facilities shall be located within easy access to residents.
- 7. Adult day service centers shall provide eating and resting areas consistent with the number and needs of the clients being served.
- 8. Adult day service centers shall provide easily accessible toilet facilities, hand washing facilities and paper towel dispensers.
- 9. The center shall be accessible to clients with supportive devices for ambulation or who are in wheelchairs.

C. RECORDS AND INFORMATION

Adult day service providers shall keep such records and information necessary to document the services provided to clients receiving adult day services. Medical Information Records shall include but not be limited to:

- 1. Medications the client is taking and whether they are being self-administered.
- 2. Special dietary needs, if any.
- 3. Restrictions on activities identified by physician in the case plan.

D. STAFFING

All adult day service centers shall have staff who have been trained in current cardiopulmonary resuscitation, seizure prophylaxis and control and brain injury. Adequate staff shall be on the premises at all times to ensure:

1. Supervision of clients at all times during the operating hours of the program.
2. Immediate response to emergency situations to assure the welfare of clients.
3. Provision of prescribed recreational and social activities.
4. Provision of administrative, recreational, social and supportive functions of the adult day services center.

E. POLICIES

The center shall have a written policy relevant to the operation of the adult day services center. Such policy shall include but not be limited to statements describing:

1. Admission criteria that qualify clients to be appropriately served in the center.
2. Interview procedures conducted for qualified clients and/or family members prior to admission to the center.
3. The meals and nourishments that will be provided, including special diets.
4. The hours that the clients will be served in the center and days of the week services will be available.
5. The personal items participants may bring with them to the center.
6. A written signed contract to be drawn up between the client or responsible party and the center outlining rules and responsibilities of the center and of the client. Each party of the contract will have a copy.
7. A statement of the center's policy for providing drop in care or day respite.

F. REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

1. Reimbursement for adult day services shall be based upon a single a single all-inclusive payment rate per unit of service for each participating provider.
2. Each provider will be paid on a per diem statewide uniform rate. The rate of payment shall be subject to available appropriations and may be the lower of the billed amount or the Medicaid allowable rate which is determined by multiplying the number of units times a rate established by the Department

8.515.80 DAY TREATMENT

A. DEFINITION

Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the recipient lives.

B. PROGRAM COMPONENTS, POLICIES AND PROCEDURES

1. Treatment plans are coordinated by a comprehensive interdisciplinary team which includes the recipient and his/her family and provides for consolidation of services in one location.
2. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, case management, and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan.
3. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statute.
4. The provider shall network with all allied medical professionals and other community based resource providers.
5. Services include social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management).
6. Crisis situations with family, client or staff shall be addressed through counseling and referral to appropriate professionals.
7. Behavioral programs shall contain specific guidelines on treatment parameters and methods.
8. There shall be regular contact and meetings with the clients and their families to discuss treatment plan progress and revision.
9. Discharge planning will include the development of a plan which considers safety, environmental modification to support individual function, education of the family and caregiver, recommendations for the future, and referral to additional community resources.
10. Each entity must have a process, verified in writing, by which a client is made aware of the process for filing a grievance.
11. Complaints by the client or family are handled within a 24 hour period from the time of complaint by at least telephone contact.
12. Transportation between therapeutic tasks in the community shall be included in the per diem cost of day treatment.

13. There shall be an inform and consent mechanism by which the client, family medical proxy or substitute decision maker is made aware of the inherent risks associated with community based rehabilitation programs. Examples of such risks might include a greater likelihood of falling accidents, traffic hazards and access to drugs or alcohol.

C. HUMAN RIGHTS

Every person receiving HCBS-BI services has the following rights:

1. Every person shall mutually develop and sign their treatment plan.
2. Every person has the right to enjoy freedom of thought, conscience, and religion.
3. Every person has the right to live in a clean, safe environment.
4. Every person has the right to have his or her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his her life.
5. Every person has the right to be free from physical abuse and inhumane treatment.
6. Every person has the right to be protected from all forms of sexual exploitation.
7. Every person has the right to access necessary medical care which is adequate and appropriate to their condition.
8. Every person has the right to communicate with significant others.
9. Every person has the right to reasonable enjoyment of privacy in personal conversations.
10. Every person has the right to have access to telephones, both to make and receive calls in privacy.
11. Every person has the right to have frequent and convenient opportunities to meet with visitors.
12. Every person has the right to the same consideration and treatment as anyone else regardless of face, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status, or disability.
13. Every person who acts as his own legal guardian has the right to accept treatment of his/her own free will.
14. Nothing in this pan shall be construed to prohibit necessary assistance as appropriate, to those individuals who may require such assistance to exercise their rights.
15. Every person has the right to be free of physical restraint unless physical intervention is necessary to prevent such body movement that is likely to result in imminent injury to self or others, and only if alternative techniques have failed. Mechanical restraints are not allowed.

D. DOCUMENTATION

1. Intake information shall include a complete neuropsychological assessment and all pertinent medical documentation from inpatient and outpatient therapy and social history to identify key treatment components and communicate the functional implications of treatment goals.
2. Initial treatment plan development and evaluations will occur within a two week period following admission.
3. Treatment plan goals and objectives shall reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.
4. Specific treatment modalities outlined in the treatment plan shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and treatment plans will be reviewed and modified as appropriate.
5. Progress notes will be kept to support specific treatment modalities rendered by date and signed by the therapist providing the service.

E. CERTIFICATION STANDARDS

1. Directors of day treatment programs shall have professional licensure in a health related program in combination with at least 2 years of experience in head trauma rehabilitation programming.
2. All providers shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.
3. The agency shall provide a clean environment, free of obstacles that could pose a hazard to client health and safety.
4. Agencies shall provide lockers or a safe place for clients' personal items.
5. Day treatment centers shall provide age appropriate activities and provide eating and resting areas consistent with the number and needs of the clients being served.
6. The center shall be accessible according to guidelines established by the Americans with Disabilities Act.
7. Personnel shall have training appropriate to the medical needs of the clients served including seizure management training, CPR certification, non-violent crisis intervention, and personal care standards according to SECTION-PERSONAL CARE 8.489.40.

F. REIMBURSEMENT

Day treatment services will be paid on a per diem basis at a rate to be determined by the Department. In order for a provider to be paid for a day of treatment, a client must have attended and received therapeutic intervention which is substantiated by case file notes signed by the rendering therapist.

8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.A DEFINITIONS

Activities of Daily Living (ADLs) mean basic self-care activities, including mobility, bathing, toileting, dressing, eating, transferring, support for memory and cognition, and behavioral supervision.

Assistance means the use of manual methods to guide, assist, with the initiation or completion of voluntary movement or functioning of an individual's body through the use of physical contact by others, except for the purpose of providing physical restraint.

Assistive Technology Devices means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

Authorized Representative means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to assist the client in acquiring and utilizing supports and services.

Behavioral Management and Education means services as defined in 10 CCR 2505-10 § 8.516.40.A and inclusions as defined at § 8.516.40.B, as an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the client's ability to remain integrated in the community.

Case Management Agency (CMA) means an agency within a designated service area where an applicant or client can obtain Case Management services. CMAs include Single Entry Points (SEP), Community Centered Boards (CCB), and private case management agencies.

Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and person-centered Service Plan for the client, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.

Critical Incident means an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a client that could have, or has had, a negative impact on the mental and/or physical well-being of a client in the short or long term. A critical incident includes accidents, suspicion of abuse, neglect, or exploitation, and criminal activity.

Department means the Department of Health Care Policy and Financing.

Health Maintenance Activities means those routine and repetitive health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These activities include, but are not limited to, catheter irrigation, administration of medication, enemas, suppositories, and wound care.

Independent Living Skills Training means services designed and directed at the development and maintenance of the client's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

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.

Interdisciplinary Team means a group of people responsible for the implementation of a client's individualized care plan, including the client receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by the client's needs and preferences, who are assembled in a cooperative manner to develop or review the person-centered care plan.

Personal Care Services includes providing assistance with eating, bathing, dressing, personal hygiene or other activities of daily living. When specified in the service plan, Personal Care Services may also include housekeeping chores such as bed making, dusting, and vacuuming. Housekeeping assistance must be incidental to the care furnished or essential to the health and welfare of the individual rather than for the benefit of the individual's family.

Person-Centered Care Plan is a service plan created by a process that is driven by the individual and can also include people chosen by the individual. It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the client needs to function safely in the community.

Protective Oversight is defined as monitoring and guidance of a client to assure his/her health, safety, and well-being. Protective oversight includes, but is not limited to: monitoring the client while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the client to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the client's choice and ability to travel and engage independently in the wider community, and providing guidance on safe behavior while outside the Supportive Living Program.

Room and Board is defined as a comprehensive set of services that include lodging, routine or basic supplies for comfortable living, and nutritional and healthy meals and food for the client, all of which are provided by the Supportive Living Program provider, and are not included in the per diem.

SLP certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to HCPF after the Supportive Living Program (SLP) provider has met all licensing requirements as an Assisted Living Residence (ALR), in addition to all requirements in these regulations at 10 CCR 2505-10, § 8.515.85.

8.515.85.B CLIENT ELIGIBILITY

1. Supportive Living Program services are available to individuals who meet all of the following requirements:
 - a. Clients are determined functionally eligible for Home and Community Based Services Brain Injury waiver by a certified case management agency;
 - b. Clients are enrolled in the Home and Community Based Services Brain Injury waiver; and
 - c. Clients require the specialized services provided under the Supportive Living Program as determined by assessed need.

8.515.85.C SUPPORTIVE LIVING PROGRAM INCLUSIONS

1. Supportive Living Program services consist of structured services designed to provide:
 - a. Assessment;
 - b. Protective Oversight and supervision;

- c. Behavioral Management and Education;
- d. Independent Living Skills Training in a group or individualized setting to support:
 - i. Interpersonal and social skill development;
 - ii. Improved household management skills; and
 - iii. Other skills necessary to support maximum independence, such as financial management, household maintenance, recreational activities and outings, and other skills related to fostering independence;
- e. Community Participation;
- f. Transportation between therapeutic activities in the community;
- g. Activities of Daily Living (ADLs);
- h. Personal Care and Homemaker services; and
- i. Health Maintenance Activities.

2. Person-Centered Care Planning

Supportive Living Program providers must abide by the Person-Centered Care Planning process. Providers will work with Case Management Agencies to ensure coordination of a client's Person-Centered Care Plan. Additionally, Supportive Living Program providers must provide the following actionable plans for all HCBS-BI waiver clients updated every six (6) months:

- a. Transition Planning; and
- b. Goal Planning.

These elements of a Person-Centered Care Plan are intended to ensure the client actively engages in his or her care and activities as well as ensure he or she is able to transition to any other type of setting or service at any given time.

3. Exclusions

The following are not included as components of the Supportive Living Program:

- a. Room and board; and
- b. Additional services which are available as a State Plan benefit or other HCBS-BI waiver service. Examples include, but are not limited to: physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, long term home health, and private duty nursing.

8.515.85.D PROVIDER LICENSING AND CERTIFICATION REQUIREMENTS

- 1. Supportive Living Program providers shall be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. 7.

- a. Providers that provided and billed SLP services prior to December 31, 2014, either licensed by CDPHE as an ALR pursuant to 6 CCR 1011-1, Ch. 7, as a Home Care Agency Class A (HCA) pursuant to 6 CCR 1011-1, Ch. 26, or under another certification approved by the Department shall be considered existing providers.
 - b. Existing providers not fully in compliance with the requirements of § 8.515.85.D or § 8.515.85.I may continue to provide services under a request for exception and plan for compliance approved by the Department until they become fully compliant. Existing providers shall submit a renewal request for exception and plan of compliance to the Department each year for review and approval.
 - i. Existing providers must show coordination with CDPHE and the Colorado Division of Fire Prevention & Control (DFPC) and their approval of progress with a plan of compliance with this request. The Department shall coordinate with CDPHE and DFPC in the application of regulatory requirements of both license and certification requirements.
2. In addition to the requirements of § 8.515.85.D.1, Supportive Living Program providers must also receive SLP Certification by CDPHE. CDPHE issues or renews a Certification when the provider is in full compliance with the requirements set out in these regulations. Certification is valid for three years from the date of issuance unless voluntarily relinquished by the provider, revoked, suspended, or otherwise sanctioned pursuant to these regulations.
3. No Certification shall be issued or renewed by CDPHE if the owner, applicant, or administrator of the Supportive Living Program has been convicted of a felony or of a misdemeanor involving moral turpitude as defined by law or involving conduct that CDPHE determines could pose a risk to the health, safety, and welfare of clients.
4. In addition to meeting the requirements of this section, Supportive Living Program providers shall be licensed in accordance with C.R.S. §§ 25-1.5-103 (2013) and 25-3-101, et seq. (2013). Supportive Living Program providers who are Assisted Living Residences shall be licensed in accordance with C.R.S. § 25-27-101, et seq. (Jul. 1, 2013). These statutes are hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.
5. CDPHE may deny, suspend, revoke, or not renew the Certification of any Supportive Living Program provider who is out of compliance with the requirements of these regulations. Providers may appeal this process pursuant to the State Administrative Procedure Act, C.R.S. § 24-4-101, et seq. (2013).

8.515.85.E PROVIDER RESPONSIBILITIES

Supportive Living Program providers must follow all person-centered planning initiatives undertaken by the State to ensure client choice.

8.515.85.F HCBS PROGRAM CRITERIA

1. All HCBS Program Criteria must be fully implemented in accordance with the final Department transition plan for compliance with federal Home and Community-Based Settings requirements. The federal regulations can be found at 42 C.F.R., Chapter IV, Parts 430, 431, 435, 436, 440, 441, and 447 (Mar. 17, 2014), which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

The following will be used to establish program criteria for Supportive Living Program providers in establishing a home-like environment pursuant to 42 C.F.R. § 440.180. In accordance with 42 C.F.R. § 441.301, the setting must:

- a. Be integrated in and support full access to the greater community;
- b. Be selected by the client from among setting options;
- c. Ensure client rights of privacy, dignity, and respect, and freedom from coercion and restraint;
- d. Optimize individual initiative, autonomy, and independence in making life choices;
- e. Facilitate client choice regarding services and supports, and who provides them;
- f. Put in place a lease or other written agreement providing similar protections for the client that addresses eviction processes and appeals;
- g. Ensure privacy in the client's unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;
- h. Ensure that clients have the freedom and support to control their own schedules and activities, and have access to food at any time;
- i. Each client shall have the right to receive and send packages. No client's outgoing packages shall be opened, delayed, held, or censored by any person;
- j. Each client has the right to receive and send sealed, unopened correspondence. No client's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person;
- k. Enable clients to have visitors of their choosing at any time; and
- l. Be physically accessible.

2. The provider must ensure adherence to all state assurances set forth at 42 C.F.R. § 441.302 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

3. Exceptions

Exceptions exist to the aforementioned HCBS Program Criteria listed in Section 8.515.85.F.1 of this rule when clear rationale and reasoning exist and is supported by appropriate documentation. These exceptions are for the corresponding sections in Section 8.515.85.F.1 of this rule, and are as follows:

- a. HCBS Program Criteria under 8.515.85.F.1, a through k:

Requirements of program criteria may be modified if supported by a specific assessed need and justified and agreed to in the person-centered care plan pursuant to 42 C.F.R. § 441.302 (Jan. 16, 2014). The following requirements must be documented in the person-centered care plan:

- i. Identify a specific and individualized assessed need.
 - ii. Document the positive interventions and supports used prior to any modifications to the person-centered care plan.
 - iii. Document less intrusive methods of meeting the need that have been tried but did not work.
 - iv. Include a clear description of the modification that is directly proportionate to the specific assessed need.
 - v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - vii. Include the informed consent of the individual.
 - viii. Include an assurance that interventions and supports will cause no harm to the individual.

- b. HCBS Program Criteria under 8.515.85.F.1.b and e:

- i. When a client chooses to receive Home and Community-Based Services in a provider-owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the client cannot choose an alternative provider to deliver services that are included in the bundled rate.

- ii. For any services that are not included in the bundled rate, the client may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle.
- iii. To illustrate these HCBS Program Criteria b and e requirements by way of example, if a program provides habilitation connected with daily living and on-site supervision under a bundled rate, an individual is choosing the residential provider for those two services when he or she chooses the residence. The individual has free choice of providers for any other services in his or her service plan, such as therapies, home health or counseling.

c. HCBS Program Criteria under 8.515.85.F.1.c:

When a client needs assistance with challenging behavior, including a client whose behavior is dangerous to himself, herself, or others, or when the client engages in behavior that results in significant property destruction, the Supportive Living Program must properly create service and support plans detailing plans to appropriately address these behaviors.

d. HCBS Program Criteria under 8.515.85.F.1.g:

Requirements for a lockable entrance door may be modified if supported by a specific assessed need and justified and agreed to in the person-centered service plan pursuant to 42 C.F.R. § 441.302 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.515.85.G STAFFING

- 1. The Supportive Living Program provider shall ensure sufficient staffing levels to meet the needs of clients, and shall meet all other staffing requirements pursuant to 6 CCR 1011-1, Ch. 7, § 1.104(4)(a), which states the following:
 - a. The owner shall employ sufficient staff to ensure the provision of services necessary to meet the needs of the residents; and
 - b. In determining staffing, the facility shall give consideration to factors including but not limited to:
 - i. Services to meet the residents' needs,
 - ii. Services to be provided under the care plan, and
 - iii. Services to be provided under the resident agreement.

- c. Each facility shall ensure that at least one staff member who has the qualifications and training listed under Sections 1.104(3)(e) and (f), and who shall be at least 18 years of age, is present in the facility when one or more residents is present. These regulations are hereby incorporated by reference. The incorporation of these regulations exclude later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

In addition to these regulations, staff should be trained in how to work with an individual or individuals in difficult situations that may arise in the course of their work.

2. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in relevant precautions and emergency procedures, including first aid, to ensure the safety of the clientele. The SLP provider shall adhere to all other regulations pursuant to 6 CCR 1011-1, Ch. 7, §§ 1.103(8) and § 1.104(1)-(2) (Aug. 14, 2013), which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.
3. Within one month of the date of hire, the Supportive Living Program provider shall provide adequate training for staff on each of the following topics:
 - a. Crisis prevention;
 - b. Identifying and dealing with difficult situations;
 - c. Cultural competency;
 - d. Infection control; and
 - e. Grievance and complaint procedures.
4. Prior to providing direct care, the Supportive Living Program provider shall provide to the operator, staff, and volunteers an orientation of the location in which the program operates and adequate training on person-centered care planning.
5. All staff training shall be documented. Copies of person-centered care plan training and related documentation must be submitted to the Department. Copies must also be submitted for inspection and approval upon changing the training curriculum.
6. In addition to the relevant requirements imposed by CDPHE in 6 CCR 1011-1 Ch. 7 on Assisted Living Residence, 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.
7. The provider shall employ or contract for behavioral services and skill training services according to client needs.

8. The Supportive Living Program provider shall employ staff qualified by education, training, and experience according to orientation and training requirements indicated within 10 CCR 2505-10, § 8.525.85.G. The Supportive Living Program shall have staff on duty as necessary to meet the needs of clients at all times, so that provision of services is not dependent upon the use of clients to perform staff functions. Volunteers may be utilized in the home but shall not be included in the provider's staffing plan in lieu of employees.
9. The Supportive Living Program provider shall have written personnel policies. Each staff member shall be provided a copy upon employment and the administrator or designee shall explain such policies during the initial staff orientation period.
10. All Supportive Living Program provider staff, prospective staff, and volunteers shall undergo a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider.

8.515.85.H CLIENT RIGHTS AND PROPERTY

1. Clients shall have all rights stated in 10 CCR 2505-10 § 8.515.85.F.1, (HCBS Program Criteria) and in accordance with 42 C.F.R. § 441.301 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.
2. The provider shall have policies on management of client funds and property consistent with those at 6 CCR 1011-1 Ch. 7, §1.105(3), which states the following:
 - a. A facility may enter into a written agreement with the resident or resident's legal representative for the management of a resident's funds or property. However, there shall be no requirement for the facility to handle resident funds or property.
 - i. Written Agreement. A resident or the resident's legal representative may authorize the owner to handle the resident's personal funds or property. Such authorization shall be in writing and witnessed and shall specify the financial management services to be performed.
 - ii. Fiduciary Responsibility. In the event that a written agreement for financial management services is entered into, the facility shall exercise fiduciary responsibility for these funds and property, including, but not limited to, maintaining any funds over the amount of five hundred dollars (\$500) in an interest bearing account, separate from the general operating fund of the facility, which interest shall accrue to the resident.
 - iii. Surety Bond. Facilities which accept responsibility for residents' personal funds shall post a surety bond in an amount sufficient to protect the residents' personal funds.
 - iv. Accounting.

- 1) A running account, dated and in ink, shall be maintained of all financial transactions. There shall be at least a quarterly accounting provided to the resident or legal representative itemizing in writing all transactions including at least the following: the date on which any money was received from or disbursed to the resident; any and all deductions for room and board and other expenses; any advancements to the resident; and the balance.
 - 2) An account shall begin with the date of the first handling of the personal funds of the resident and shall be kept on file for at least three years following termination of the resident's stay in the facility. Such record shall be available for inspection by the Department.
- v. Receipts. Residents shall receive a receipt for and sign to acknowledge disbursed funds.
3. Upon client request, a client shall be entitled to receive available money or funds held in trust.

8.515.85.I FIRE SAFETY AND EMERGENCY PROCEDURES

1. Applicants for initial provider Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by DFPC, in accordance with 8 CCR 1507-31 (Aug. 26, 2013), which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.
2. Existing SLP providers as defined at 10 CCR 2505-10, § 8.515.85.D.1 may continue, through the use of a Department-approved exception as defined in 10 CCR 2505-10, § 8.515.85.D.1.b, to utilize existing fire safety systems approved by the local fire authority having jurisdiction until they demonstrate compliance with 8 CCR 1507-31 provided they remain in compliance with the following:
 - a. There is no change in evacuation status of a client,
 - b. nor a client admission or discharge that alters the residence overall fire safety rating, and
 - c. no renovation of 25 percent or greater to the total interior of the physical plant is performed.
 - d. If such a change, admission, discharge or renovation occurs, the home shall be required to meet the applicable standards referenced in 10 CCR 2505-10 § 8.515.85.I.1.
3. Providers shall develop written emergency plans and procedures for fire, serious illness, severe weather, disruption of essential utility services, and missing persons for each client. Emergency and evacuation procedures shall be consistent with any relevant local and state fire and life safety codes and the provisions set forth in 6 CCR 1011-1 Ch. 7, §1.104(5)(b) and (c), which state the following:

- a. Emergency plan. The emergency plan shall include planned responses to fire, gas explosion, bomb threat, power outages, and tornadoes. Such plan shall include provisions for alternate housing in the event evacuation is necessary.
 - b. Disclosure to residents. Within three (3) days of admission, the plan shall be explained to each resident or legal representative, as appropriate.
 - c. The policy shall describe the procedures to be followed by the facility in the event of serious illness, serious injury, or death of a resident.
 - d. The policy shall include a requirement that the facility notify an emergency contact when the resident's injury or illness warrants medical treatment or face-to-face medical evaluation. In the case of an emergency room visit or unscheduled hospitalization, a facility must notify an emergency contact immediately, or as soon as practicable.
4. Within three (3) days of scheduled work or commencement of volunteer service, the program shall provide adequate training for staff in emergency and fire escape plan procedures.
5. Staff and clients shall have training on, and practices of, emergency plans and procedures, in addition to fire drills, at intervals throughout the year. There shall be at least two fire drills conducted annually during the evening and overnight hours while clients are sleeping. All such practices and training shall be documented and reviewed every six (6) months. Such documentation shall include any difficulties encountered and any needed adaptations to the plan. Such adaptations shall be implemented immediately upon identification.

8.515.85.J ENVIRONMENTAL AND MAINTENANCE REQUIREMENTS

1. A Supportive Living Program residence shall be designed, constructed, equipped, and maintained to ensure the physical safety of clients, personnel, and visitors as required by 6 CCR 1011-1, Ch. 7, § 1.111, regarding the interior and exterior environment:
- a. Interior Environment: All interior areas including attics, basements, and garages shall be safely maintained. The facility shall provide a clean, sanitary environment, free of hazards to health and safety.
 - i. Potential Safety Hazards include:
 - 1) Cooking shall not be allowed in bedrooms. Residents may have access to an alternative area where minimal food preparation such as heating or reheating food or making hot beverages is allowed. In those facilities which make housing available to residents through apartments rather than resident bedrooms, cooking may be allowed in accordance with house rules. Only residents who are capable of cooking safely shall be allowed to do so. The facility shall document such assessment.
 - 2) Extension cords and multiple use electrical sockets in resident rooms shall be limited to one per resident.
 - 3) Power strips are permitted throughout the facility with the following limitations:

- a) The power strip must be provided with overcurrent protection in the form of a circuit breaker or fuse.
 - b) The power strip must have a UL (underwriters laboratories) label.
 - c) The power strips cannot be linked together when used.
 - d) Extension cords cannot be plugged into the power strip.
 - e) Power strips can have no more than six receptacles.
 - f) The use will be restricted to one power strip per resident per bedroom.
- 4) Personal Appliances shall be allowed in resident bedrooms only under the following circumstances:
- a) Such appliances are not used for cooking;
 - b) Such appliances do not require use of an extension cord or multiple use electrical sockets;
 - c) Such appliance is in good repair as evaluated by the administrator;
 - d) Such appliance is used by a resident who the administrator believes to be capable of appropriate and safe use. The facility shall document such assessment.
- 5) Electric blanket/Heating pad. In no event shall a heating pad or electric blanket be used in a resident room without either staff supervision or documentation that the administrator believes the resident to be capable of appropriate and safe use.
- 6) All interior areas including attics, basements, and garages shall be free from accumulations of extraneous materials such as refuse, discarded furniture, and old newspapers.
- 7) Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.
- 8) Kerosene (fuel fired) heaters shall not be permitted within the facility. Electric or space heaters shall not be permitted within resident bedrooms and may only be used in common areas of the facility if owned, provided, and maintained by the facility.
- 9) Fire resistant wastebaskets. Enclosed areas on the premises where smoking is allowed shall be equipped with fire resistant wastebaskets. In addition, resident rooms occupied by smokers, even when house rules prohibit smoking in resident rooms, shall have fire resistant wastebaskets.

ii. Potential Infection/Injury Hazards

- 1) Insect/rodent infestations. The facility shall be maintained free of infestations of insects and rodents and all openings to the outside shall be screened.
 - 2) Storage of hazardous substances. Solutions, cleaning compounds and hazardous substances shall be labeled and stored in a safe manner.
 - iii. Heating, Lighting, and Ventilation
 - 1) Each room in the facility shall be installed with heat, lighting and ventilation sufficient to accommodate its use and the needs of the residents.
 - 2) All interior and exterior steps and interior hallways and corridors shall be adequately illuminated.
 - iv. Water
 - 1) There shall be an adequate supply of safe, potable water available for domestic purposes.
 - 2) There shall be a sufficient supply of hot water during peak usage demands.
 - 3) Hot water shall not measure more than 120 degrees Fahrenheit at taps which are accessible by resident.
 - v. There shall be a telephone available for regular telephone usage by residents and staff.
- b. Exterior Environment
 - i. Potential Safety Hazards
 - 1) Exterior premises shall be kept free of high weeds and grass, garbage and rubbish. Grounds shall be maintained to prevent hazardous slopes, holes, or other potential hazards.
 - 2) Exterior staircases of three (3) or more steps and porches shall have handrails. Staircases and porches shall be kept in good repair.
2. The Supportive Living Program provider shall comply with all State and Local Laws/Codes regarding furnishings, equipment and supplies pursuant to 6 CCR 1011-1, Ch. 7, § 1.112 (Aug. 14, 2013), which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.
3. Clients shall be allowed free use of all common living areas within the residence, with due regard for privacy, personal possessions, and safety of clients.

4. Supportive Living Program providers shall develop and implement procedures for the following:
 - a. Handling of soiled linen and clothing;
 - b. Storing personal care items;
 - c. General cleaning to minimize the spread of pathogenic organisms; and
 - d. Keeping the home free from offensive odors and accumulations of dirt and garbage.
5. The Supportive Living Program provider shall ensure that each client is furnished with his or her own personal hygiene and care items. These items are to be considered basic in meeting an individual's needs for hygiene and remaining healthy. Any additional items may be selected and purchased by the client at his or her discretion.
6. There shall be adequate bathroom facilities for individuals to access without undue waiting or burden.
7. The Supportive Living Program provider shall comply with all bathroom requirements regarding handrails, handholds, and other needs of clients pursuant to 6 CCR 1101-1 Ch. 7, § 1.112(4)
 - a. A full bathroom shall consist of at least the following fixtures: toilet, hand washing sink, toilet paper dispenser, mirror, tub or shower, and towel rack.
 - b. There shall be a bathroom on each floor having resident bedrooms which is accessible without requiring access through an adjacent bedroom.
 - c. In any facility which is occupied by one or more residents utilizing an auxiliary aid, the facility shall provide at least one full bathroom as defined herein with fixtures positioned so as to be fully accessible to any resident utilizing an auxiliary aid.
 - d. Bathtubs and shower floors shall have non-skid surfaces.
 - e. Grab bars shall be properly installed at each tub and shower, and adjacent to each toilet in any facility which is occupied by one or more residents utilizing an auxiliary aid or as otherwise indicated by the needs of the resident population.
 - f. Toilet seats shall be constructed of non-absorbent material and free of cracks.
 - g. The use of common personal care articles, including soap and towels, is prohibited.
 - h. Toilet paper in a dispenser shall be available at all times in each bathroom of the facility.
 - i. Liquid soap and paper towels shall be available at all times in the common bathrooms of the facility.
8. Each client shall have access to telephones, both to make and to receive calls in privacy.

9. The Supportive Living Staff shall maintain a clean, safe, and healthy environment, including appropriate cleaning techniques and sanitary meal preparation and delivery according to 6 CCR 1011-1, Ch. 7, § 1.109, which requires the following:
 - a. For facilities with less than twenty (20) beds, food shall be prepared, handled and stored in a sanitary manner, so that it is free from spoilage, filth, or other contamination, and shall be safe for human consumption.
 - b. Hazardous materials shall not be stored with food supplies.
 - c. Facilities with twenty (20) beds or more shall comply with CDPHE's March 1, 2013 regulations on Colorado Retail Food Establishments at 6 CCR 1010-2, which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.515.85.K COMPLAINTS AND GRIEVANCES

Each client will have the right to voice grievances and recommend changes in policies and services to both the Department and/or the Supportive Living Program provider. Complaints and grievances made to the Department shall be made in accordance with the grievance and appeal process in 10 CCR 2505-10 § 8.209.

8.515.85.M RECORDS

1. Supportive Living Providers shall develop policies and procedures to secure client information against potential identity theft. Confidentiality of medical records shall be maintained in compliance with 45 C.F.R. §§ 160.101, et seq. and 164.102, et seq. (2014), which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.
2. All medical records for adults (persons eighteen (18) years of age or older) shall be retained for no less than six (6) years after the last date of service or discharge from the Supportive Living Program. All medical records for minors shall be retained after the last date of service or discharge from the Supportive Living Program for the period of minority plus six (6) years.

8.515.85.N REIMBURSEMENT

1. Supportive Living Program services shall be reimbursed according to a per diem rate, using a methodology determined by the Department. Authority for the Department to define and limit covered services is found at C.R.S. § 25.5-1-202 (2013).
2. The methodology for calculating the per diem rate shall be based on a weighted average of client acuity scores.

3. The Department shall establish a maximum allowable room and board charge for clients in the Supportive Living Program. Increases in payment shall be permitted in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises grant amounts.
 - a. Room and board shall not be a benefit of HCBS-BI residential services. Clients shall be responsible for room and board in an amount not to exceed the Department established rate.

8.515.85.O CALCULATION OF CLIENT PAYMENT (PETI)

1. When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, the State may reduce Medicaid payment for SLP residential services. The case manager shall calculate the client payment (PETI) for 300% eligible HCBS-BI clients according to the following procedures:
 - a. For 300% eligible clients who receive residential services, the case manager shall complete a State-prescribed form which calculates the client payment according to the following procedures:
 - i. An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed HCBS residential services room and board amount shall be paid: and
 - ii. For an individual with financial responsibility for others:
 - 1) If the individual is financially responsible for only a spouse, an amount equal to the state Aid to the Needy Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income; or
 - 2) If the individual is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding income from part-time employment earnings of a dependent child who is either a full-time student or a part-time student as defined at Section 8.100.1) shall be deducted from the client's gross income; and
 - iii. Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the client's gross income as follows:
 - 1) Health insurance premiums if health insurance coverage is documented in the eligibility system: deductible or co-insurance charges, and
 - 2) Necessary dental care not to exceed amounts equal to actual expenses incurred, and

- 3) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred, and
- 4) Medications, with the following limitations:
 - a) The need for such medications shall be documented in writing by the attending physician. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.
 - b) Medications which may be purchased with the client's Medicaid Identification Card shall not be allowed as deductions.
 - c) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.
 - d) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.
 - e) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.
- 5) Other necessary medical or remedial care shall be deducted from the client's gross income, with the following limitations:
 - a) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.
 - b) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.
- 6) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

- 7) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.
- iv. Any remaining income shall be applied to the cost of the SLP residential services, as defined at Section 8.515.85 and shall be paid by the client directly to the facility; and
- v. If there is still income remaining after the entire cost of residential services are paid from the client's income, the remaining income shall be kept by the client and may be used as additional personal needs or for any other use that the client desires, except that the residential service provider shall not charge more than the Medicaid rate for that service.
- b. Case managers shall inform HCBS-BI clients receiving residential services of their client payment obligation on a form prescribed by the state at the time of the first assessment visit by the end of each plan period; or within ten (10) working days whenever there is a significant change in the client payment amount.
 - i. Significant change is defined as fifty dollars (\$50) or more.
 - ii. Copies of client payment forms shall be kept in the client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request, according to Section 8.515.7, or if requested by the state for monitoring purposes.

8.516.10 INDEPENDENT LIVING SKILLS TRAINING

A. DEFINITIONS

- 1. Independent Living Skills Training (ILST) means services designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community. ILST may be provided in the client's residence, in the community, or in a group living situation.
- 2. ILST program service plans are plans designed and directed specifically to the service inclusions of the ILST program that meet the need of the client in their ability to independently sustain himself/herself physically, emotionally, and economically in the community. This plan is developed with the client and the provider.
- 3. ILST Trainers are individuals trained in accordance with guidelines listed below tasked with providing the service inclusions to the program participant.

4. Person-Centered Care Plan is a plan of care created by a process that is driven by the individual and can also include people chosen by the individual, as well as the appropriate health care professional and the designated independent living ILST trainer(s). It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the client needs to function safely in the community. This plan is developed by the client with the case management agency.

B. INCLUSIONS

1. Reimbursable services are limited to the assessment, training, maintenance, supervision, assistance, or continued supports of the following skills:
 - a. Self-care, including but not limited to basic personal hygiene;
 - b. Medication supervision and reminders;
 - c. Household management;
 - d. Time management skills training;
 - e. Safety awareness skill development and training;
 - f. Task completion skill development and training;
 - g. Communication skill building;
 - h. Interpersonal skill development;
 - i. Socialization, including but not limited to acquiring and developing appropriate social norms, values, and skills;
 - j. Recreation, including leisure and community integration activities;
 - k. Sensory motor skill development;
 - l. Benefits coordination, including activities related to the coordination of Medicaid services;
 - m. Resource coordination, including activities related to coordination of community transportation, community meetings, neighborhood resources, and other available public and private resources;
 - n. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting.
2. All Independent Living Skills Training shall be documented in the person-centered care plan. Reimbursement is limited to services described in the person-centered care plan.

C. PROVIDER CERTIFICATION STANDARDS

1. Provider agencies must have valid licensure and certification as well as appropriate professional oversight.

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- a. Agencies seeking to provide ILST services must have a valid Home Care Agency Class A or B license or an Assisted Living Residency license and Transitional Living Program provider certification from the Department of Public Health and Environment.
 - b. Agencies must employ an ILST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, brain injury, and a degree within a relevant field.
 - i. This coordinator must review ILST program service plans to ensure client plan is designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community.
 - c. Any component of the ILST plan that may contain activities outside the scope of the ILST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the client. These professionals must be in good standing as one of the following:
 - i. Occupational Therapist;
 - ii. Physical Therapist;
 - iii. Registered Nurse;
 - iv. Speech Language Pathologist;
 - v. Psychologist;
 - vi. Neuropsychologist;
 - vii. Medical Doctor;
 - viii. Licensed Clinical Social Worker;
 - ix. Licensed Professional Counselor.
 - d. Professionals providing components of the ILST plan can include individuals who are members of agency staff, contracted staff, or external licensed and certified professionals who are fully aware of duties conducted by ILST trainers.
 - e. All ILST service plans containing any professional activity must be reviewed and authorized at least every 6 months, or as needed, by professionals responsible for oversight as referenced in 8.516.10.C.b.i-ix.
2. ILST trainers must meet one of the following education, experience, or certification requirements:
- a. Licensed health care professionals with experience in providing functionally based assessments and skills training for individuals with disabilities; or
 - b. Individuals with a Bachelor's degree and one year of experience working with individuals with disabilities; or
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- c. Individuals with an Associate's degree in a social service or human relations area and two years of experience working with individuals with disabilities; or
 - d. Individuals currently enrolled in a degree program directly related to but not limited to special education, occupational therapy, therapeutic recreation, and/or teaching with at least 3 years of experience providing services similar to ILST services; or
 - e. Individuals with 4 years direct care experience teaching or working with individuals with a brain injury or other cognitive disability either in a home setting, hospital setting, or rehabilitation setting.
- 3. The agency shall administer a series of training programs to all ILST trainers.
 - a. Prior to delivery of and reimbursement for any services, ILST trainers must complete the following trainings:
 - i. Person-centered care approaches; and
 - ii. HIPAA and client confidentiality; and
 - iii. Basics of brain injury including at a minimum;
 - 1. Basic neurophysiology; and
 - 2. Impact of a brain injury on an individual; and
 - 3. Epidemiology of brain injury; and
 - 4. Common physical, behavioral, and cognitive impairments and interactions strategies; and
 - 5. Best practices in brain injury recovery; and
 - 6. Screening for a history of brain injury.
 - iv. On-the-job coaching by an incumbent ILST trainer; and
 - v. Basic safety and de-escalation techniques; and
 - vi. Training on community and public resource availability; and
 - vii. Understanding of current brain injury recovery guidelines; and
 - viii. First aid.
 - b. ILST trainers must also receive ongoing training, required annually, in the following areas:
 - i. Cultural awareness; and
 - ii. Updates on brain injury recovery guidelines; and
 - iii. Updates on resource availability.

D. REIMBURSEMENT

1. Reimbursement shall be on an hourly basis. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as independent living services. The time billed for travel shall be listed separately from the time for service provision on each visit but must be documented on the same form. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period.

8.516.30 TRANSITIONAL LIVING

A. DEFINITIONS

1. Transitional living means programs, which occur outside of the client's residence, designed to improve the client's ability to live in the community by provision of 24 hour services, support and supervision.
2. Program services include but are not limited to assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household.
3. Extraordinary therapy needs mean, for purposes of this program, a client who requires more than three hours per day of any combination of therapeutic disciplines. This includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

B. INCLUSIONS

1. All services must be documented in an approved plan of care and be prior authorized by the Department of Health Care Policy and Financing (the Department).
2. Clients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs.
3. Clients must require available paraprofessional nursing assistance on a 24 hour basis due to dependence in activities of daily living, locomotion, or cognition.
4. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a client requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for the Transitional Living Program service for a client must be documented and authorized individually by the Department.

C. EXCLUSIONS

1. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges.
2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.
3. Room and board charges are not a billable component of transitional living services.

4. Items of personal need or comfort shall be paid out of money set aside from client's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program.
5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the Department.

D. CERTIFICATION STANDARDS

Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-1-107, et, seq.,

1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs.
2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in SECTIONS following titled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS.
3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards.
4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis.
5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.
2. Clients, families, medical proxies, or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.
3. Understanding that clients of transitional living programs frequently experience behavior which may be a danger to themselves or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.
4. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve clients for whom they lack adequate resources to ensure safety of program participants and staff.

5. Upon entry into the program, discharge planning shall begin with the client and family. Transitional living programs shall work with the client and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services.
6. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.
7. During daytime hours, the ratio of staff to clients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.
8. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Department.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service related profession plus three years experience providing direct services to individuals with brain injury. A bachelor's degree with five years experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.
2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the client. These staff members will have successfully completed a training program of at least 40 hours duration.
3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.
4. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.
5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.
6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from inpatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.
2. Initial treatment plan development and evaluations will occur within a two week period following admission.

3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.
4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.
5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.
6. All transitional services must utilize licensed psychologists with two years experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.
7. Programs shall have a process verified in writing by which a client is made aware of the process for filing a grievance. Complaints by the client or family shall be handled via telephone or direct contact with the client or family.
8. Customer satisfaction surveys will be regularly performed and reviewed.
9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.
10. Client safety in the community will be assessed: safety status and recommendations will be documented.
11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.
2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the acuity-based per diem reimbursement rate established by the Department of Health Care Policy and Financing and will not bill the client in excess of his/her SSI payment or \$400 per month, whichever is less for room and board charges.

All transitional living services shall be prior authorized through submission to the Department. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond six months duration must be reauthorized with treatment plan justification and shall be submitted through the reconsideration process established by the.

8.516.40 BEHAVIORAL PROGRAMMING

A. DEFINITION

Behavioral programming and education is an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the individuals ability to remain integrated in the community.

B. INCLUSIONS

1. Programs should consist of a comprehensive assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the person's environment.
2. Behavioral programs may be provided in the community or in the client's residence unless the residence is a transitional living center which provides behavioral intervention as a treatment component
3. All behavioral programming must be documented in the plan of care and reauthorized after 30 units of service with the Brain Injury Program Coordinator.

C. CERTIFICATION STANDARDS

1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a health care professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters level Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of behavioral management concepts.
2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with brain injury if their work experience does not include at least one year of same.

D. REIMBURSEMENT

Behavioral programming must be documented on the client's care plan and prior authorized through the State Brain Injury Program Coordinator. Behavioral programming services will be paid on an hourly basis as established by the Department

8.516.50 COUNSELING

A. DEFINITIONS

Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries.

B. INCLUSIONS

1. Counseling is available to the program participant's family in conjunction with the client if they: a) have a significant role in supporting the client or b) live with or provide care to the client. "Family" includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the waiver participant.
2. Services may be provided in the waiver participant's residence, in community settings, or in the provider's office.
3. Intervention may be provided in either a group or individual setting; however, charges for group and individual therapy shall reflect differences.
4. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department of Health Care Policy and Financing as directed by certification standards listed below.
5. Family training/counseling must be carried out for the direct benefit of the client of the HCBS-BI program.
6. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as may be necessary to safely maintain the individual at home.
7. Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

1. Family training is not available to individuals who are employed to care for the recipient.

D. CERTIFICATION STANDARDS

1. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker. Certified Rehabilitation Counselor. Licensed Professional Counselor, or Licensed Clinical Psychologist.
2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years experience in providing counseling to individuals with brain injury and their families.
3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling, Individual Counseling, and Group Counseling.

8.516.60 SUBSTANCE ABUSE COUNSELING

A. DEFINITION

Substance abuse programs are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the water participant which, if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

B. INCLUSIONS

1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program
2. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver participant, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons if directly involved in the support system of the client, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager.
3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall be submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

Inpatient treatment is not a covered benefit.

D. CERTIFICATION STANDARDS

1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing.
2. Programs must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury.
3. Counselors should be certified at the Certified Addiction Counselor II level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any individual with a brain injury or their family members. A recommended training curriculum will include a three day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present), Individual Counseling, and Group Counseling.

8.516.70 RESPITE CARE

A. DEFINITIONS

1. Respite care means services provided to an eligible client on a short-term basis because of the absence or need for relief of those persons normally providing the care.
2. Respite care provider means a Class I nursing facility, an alternative care facility or an employee of a certified personal care agency which meets the certification standards for respite care specified below.

B. INCLUSIONS

1. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite client, as ordered by the physician.

C. RESTRICTIONS

1. An individual client shall be authorized for no more than a cumulative total of thirty (30) days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home or in a nursing facility.
 - A. A mix of delivery options is allowable as long as the aggregate amount of services is below thirty (30) days, or 720 hours, of respite care.
 1. In home respite is limited to no more than eight (8) hours a day.
 2. Nursing facility respite billed on a per diem.
2. Only those portions of the facility that are Medicaid certified for nursing facility services may be utilized for respite clients.

D. CERTIFICATION STANDARDS AND PROCEDURES

1. Respite care standards and procedures for nursing facilities are as follows:
 - A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.
 - B. The nursing facility does not have to maintain or hold open separately designated beds for respite clients, but may accept respite clients on a bed available basis.
 - C. For each HCBS-BI respite client, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the client. The chart must identify the client as a respite client. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

- D. An admission to a nursing facility under HCBS-BI respite does not require a new ULTC-100.2, a PASARR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or labwork as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.
 - E. The nursing facility shall have written policies and procedures available to staff regarding respite care clients. Such policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care clients.
 - F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite client's entry into the facility.
3. Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

E. REIMBURSEMENT

1. Respite care reimbursement to nursing facilities shall be as follows:
- A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-BI claim form according to fiscal agent instructions.
 - B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.
 - C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.
2. Respite care reimbursement to alternative care facilities shall be as follows:
- A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-BI claim form according to fiscal agent instructions.
 - B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.
 - C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.
3. Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

4. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI services shall not be reimbursed during the respite stay.
5. There shall be no reimbursement provided under this section for respite care in uncertified congregate facilities.

8.517 HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY WAIVER

8.517.1 DEFINITIONS OF SERVICES PROVIDED

Adult Day Services means services as defined at Section 8.491.

Complementary and Integrative Health Services means services as defined at Section 8.517.11.

Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.

Electronic Monitoring means services as defined at Section 8.488.

Home Modification means services as defined at Section 8.493.

Homemaker Services means services as defined at Section 8.490.

In-Home Support Services means services as defined at Section 8.552.

Non-Medical Transportation means services as defined at Section 8.494.

Personal Care Services means services as defined at Section 8.489.

Respite Care means services as defined at Section 8.492.

8.517.2 GENERAL DEFINITIONS

Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about beneficial physiologic and/or psychological changes.

Chiropractic Care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems.

Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.

Complementary and Integrative Health Provider means an individual or agency certified annually by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11. Denver Metro Area means the counties of Adams, Arapahoe, Denver, Douglas, and Jefferson.

Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

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/or psychological changes.

Medical Director means an individual that is contracted with the Department of Health Care Policy and Financing to provide oversight of the Complementary and Integrative Health Services and the program evaluation.

Spinal Cord Injury means an injury to the spinal cord which is further defined at 8.517.2.1.

8.517.2.1 SPINAL CORD INJURY DEFINITION

A spinal cord injury is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Spinal cord injury unspecified
2. Complete lesion of spinal cord
3. Anterior cord syndrome
4. Central cord syndrome
5. Other specified spinal cord injury
6. Lumbar spinal cord injury without spinal bone injury
7. Sacral spinal cord injury without spinal bone injury
8. Cauda equina spinal cord injury without spinal bone injury
9. Multiple sites of spinal cord injury without spinal bone injury
10. Unspecified site of spinal cord injury without spinal bone injury
11. Injury to cervical nerve root
12. Injury to dorsal nerve root
13. Injury to lumbar nerve root
14. Injury to sacral nerve root
15. Injury to brachial plexus
16. Injury to lumbosacral plexus
17. Injury to multiple sites of nerve roots and spinal plexus
18. Injury to unspecified site of nerve roots and spinal plexus
19. Injury to cervical sympathetic nerve excluding shoulder and pelvic girdles
20. Injury to other sympathetic nerve excluding shoulder and pelvic girdles

21. Injury to other specified nerve(s) of trunk excluding shoulder and pelvic girdles
22. Injury to unspecified nerve of trunk excluding shoulder and pelvic girdles
23. Paraplegia
24. Paraplegia, Unspecified
25. Paraplegia, Complete
26. Paraplegia, Incomplete
27. Quadriplegia/Tetraplegia/Incomplete – unspecified
28. Quadriplegia – C1-C4/Complete
29. Quadriplegia – C1-C4/Incomplete
30. Quadriplegia – C5-C7/Complete
31. Quadriplegia – C5-C7/Incomplete

8.517.3 LEGAL BASIS

The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver is created upon authorization of a waiver of the state-wideness requirement contained in Section 1902(a)(1) of the Social Security Act (42 U.S.C. § 1396a); and the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act (42 U.S.C. § 1396a). Upon approval by the United States Department of Health and Human Services, this waiver is granted under Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n). 42 U.S.C. §§ 1396a and 1396n are incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO 80203. Additionally, any incorporated material in these rules may be examined at any State depository library. This regulation is adopted pursuant to the authority in Section 25.5-1-301, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Section 24-4-101 et seq., C.R.S. and the Colorado Medical Assistance Act, Sections 25.5-6-1301 et seq., C.R.S.

The addition of “individual” to the Complementary and Integrative Health Provider definition in section 8.517.2, the addition of hospital level of care eligibility criteria in section 8.517.5.C, the elimination of the waitlist at section 8.517.6.1, the addition of the client’s residence as a service location at section 8.517.11.B.3 and all Medical Director responsibilities are contingent and shall not be in effect until the HCBS-SCI Waiver Renewal CO.0961.R01.00 has been approved by the Centers for Medicare and Medicaid Services (CMS).

8.517.4 SCOPE AND PURPOSE

- 8.517.4.A. The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver provides assistance to individuals with spinal cord injuries in the Denver Metro Area that require long term supports and services in order to remain in a community setting.

8.517.4.B. The HCBS-SCI waiver provides an opportunity to study the effectiveness of Complementary and Integrative Health Services and the impact the provision of these service may have on the utilization of other HCBS-SCI waiver and/or acute care services.

8.517.4.C. An independent evaluation shall be conducted no later than January 1, 2020 to determine the effectiveness of the Complementary and Integrative Health Services.

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall be offered only to individuals who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.
2. Individuals shall have a diagnosis of Spinal Cord Injury. This diagnosis must be outlined in 8.517.2.1 and documented on the individual's Professional Medical Information Page (PMIP) and in the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool.
3. Individuals shall have been determined to have a significant functional impairment as evidenced by a comprehensive functional assessment using the ULTC 100.2 assessment tool that results in at least the minimum scores required per Section 8.401.1.15.
4. Individuals shall reside in the Denver Metro Area as evidenced by residence in one of the following counties:
 - a. Adams;
 - b. Arapahoe;
 - c. Denver;
 - d. Douglas; or
 - e. Jefferson

8.517.5.B FINANCIAL ELIGIBILITY

Individuals must meet the financial eligibility requirements specified at Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.517.5.C LEVEL OF CARE CRITERIA

Individuals shall require long term support services at a level of care comparable to services typically provided in a nursing facility or hospital.

8.517.5.D NEED FOR HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY (HCBS-SCI) WAIVER SERVICES

1. Only individuals that currently receive Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services, or that have agreed to accept HCBS-SCI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-SCI waiver.

- a. Case management is not an HCBS-SCI service and shall not be used to satisfy this requirement.
 - b. The desire or need for any Medicaid services other than HCBS-SCI waiver services, as listed at Section 8.517.1, shall not satisfy this eligibility requirement.
2. Individuals that have not received at least one (1) HCBS-SCI waiver service for a period greater than 30 consecutive days shall be discontinued from the waiver.

8.517.5.E EXCLUSIONS

1. Individuals who are residents of nursing facilities or hospitals are not eligible to receive Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services.
2. HCBS-SCI clients that enter a nursing facility or hospital may not receive HCBS-SCI waiver services while admitted to the nursing facility or hospital.
 - a. HCBS-SCI clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-SCI program.
 - b. HCBS-SCI clients entering a nursing facility for Respite Care as an HCBS-SCI service shall not be discontinued from the HCBS-SCI program.

8.517.5.F COST CONTAINMENT AND SERVICE ADEQUACY

1. Individuals shall not be eligible for the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver if the case manager determines any of the following during the initial assessment and service planning process:
 - a. The individual's needs cannot be met within the Individual Cost Containment Amount.
 - b. The individual's needs are more extensive than HCBS-SCI waiver services are able to support and/or that the individual's health and safety cannot be assured in a community setting.
2. Individuals shall not be eligible for the HCBS-SCI waiver at reassessment if the case manager determines the individual's needs are more extensive than HCBS-SCI waiver services are able to support and/or that the individual's health and safety cannot be assured in a community setting.
3. Individuals may be eligible for the HCBS-SCI waiver at reassessment if the case manager determines that HCBS-SCI waiver services are able to support the individual's needs and the individual's health and safety can be assured in a community setting.
 - a. If the case manager expects that the services required to support the individual's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the individual's request for services is appropriate and justifiable based on the individual's condition.
 - i) Individuals may request of the case manager that existing services remain intact during this review process.

- ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:
 - 1) The client's appeal rights pursuant to Section 8.057; and
 - 2) Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

8.517.6 WAITING LIST

1. The number of clients who may be served through the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver during a fiscal year may be limited by the federally approved waiver.
2. Individuals determined eligible for the HCBS-SCI waiver who cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.
3. The waiting list shall be maintained by the Department.
4. The case manager shall ensure the individual meets all eligibility criteria as set forth at Section 8.517.5 prior to notifying the Department to place the individual on the waiting list.
5. The date the case manager determines an individual has met all eligibility requirements as set forth at Section 8.517.5 is the date the Department will use for the individual's placement on the waiting list.
6. When an eligible individual is placed on the waiting list for the HCBS- SCI waiver, the case manager shall provide a written notice of the action in accordance with section 8.057 et seq.
7. As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for the HCBS-SCI waiver in the order of the individual's placement on the waiting list
8. When an opening for the HCBS-SCI waiver becomes available the Department will provide written notice to the Case Management Agency.
9. Within ten business days of notification from the Department that an opening for the HCBS-SCI waiver is available the Case Management Agency shall:
 - a. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.
 - b. Update the existing functional level of care assessment in the official client record if less than six months has elapsed since the date of the previous assessment.
 - c. Reassess for eligibility criteria as set forth at 8.517.5.
 - d. Notify the Department of the individual's eligibility status.

8.517.7 START DATE FOR SERVICES

8.517.7.A. The start date of eligibility for Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall not precede the date that all of the requirements at Section 8.517.5, have been met. The first date for which HCBS-SCI waiver services may be reimbursed shall be the later of the following:

1. The date at which financial eligibility is effective.
2. The date at which the level of care and targeting criteria are certified.
3. The date at which the individual agrees to accept services and signs all necessary intake and service planning forms.
4. The date of discharge from the hospital or nursing facility.

8.517.8 CASE MANAGEMENT FUNCTIONS

8.517.8.A. The requirements at Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver.

8.517.9 PRIOR AUTHORIZATION OF SERVICES

8.517.9.A. All Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services must be prior authorized by the Department or its agent.

8.517.9.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.517.9.C. Claims for services are not reimbursable if:

1. Services are not consistent with the client's documented medical condition and functional capacity;
2. Services are not medically necessary or are not reasonable in amount, scope, frequency, and duration;
3. Services are duplicative of other services included in the client's Service Plan;
4. The client is receiving funds to purchase services; or
5. Services total more than 24 hours per day of care.

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

8.517.9.E. Payment for HCBS-SCI waiver services is also conditional upon:

- a. The client's eligibility for HCBS-SCI waiver services;
- b. The provider's certification status; and
- c. The submission of claims in accordance with proper billing procedures.

8.517.9.F. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulation and necessary to meet the client's needs.

8.517.9.G. Services requested on the PAR shall be supported by information on the Long Term Care Service Plan, the ULTC-100.2, and written documentation from the income maintenance technician of the client's current monthly income.

8.517.9.H. The PAR start date shall not precede the start date of HCBS-SCI eligibility in accordance with Section 8.517.7.

8.517.9.I. The PAR end date shall not exceed the end date of the HCBS-SCI eligibility certification period.

8.517.10 PROVIDER AGENCIES

8.517.10.A. HCBS-SCI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

8.517.11 COMPLEMENTARY AND INTEGRATIVE HEALTH SERVICES

Complementary and Integrative Health Services are limited to Acupuncture, Chiropractic Care, and Massage Therapy as defined at Section 8.517.2.

8.517.11.A. Inclusions

1. Acupuncture used for the treatment of conditions or symptoms related to the client's spinal cord injury.
2. Chiropractic Care used for the treatment of conditions or symptoms related to the client's spinal cord injury.
3. Massage Therapy used for the treatment of conditions or symptoms related to the client's spinal cord injury.

8.517.11.B. Exclusions / Limitations

1. Complementary and Integrative Health Services shall be provided only for the treatment of conditions or symptoms related to the client's spinal cord injury.
2. Complementary and Integrative Health Services shall be limited to the client's assessed need for services as determined by the Complementary and Integrative Health Provider and documented in the Complementary and Integrative Health Care Plan.
3. Complementary and Integrative Health Services shall be provided in an approved outpatient setting in accordance with 8.517.11.C.2 or in the client's residence.
4. Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.
5. Clients receiving Complementary and Integrative Health Services shall participate in an independent evaluation to determine the effectiveness of the services.
6. The Complementary and Integrative Health Services benefit is limited as follows:

- a. A client may receive each of the three individual Complementary and Integrative Health Services on a single date of service.
- b. A client shall not receive more than four (4) units of each individual Complementary and Integrative Health Service on a single date of service.
- c. A client shall not receive more than 204 units of a single Complementary and Integrative Health service during a 365 day certification period.
- d. A client shall not receive more than 408 combined units of all Complementary and Integrative Health Services during a 365 day certification period.

8.517.11.C. Certification Standards

1. Organization and Staffing

- a. Complementary and Integrative Health Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.
- b. Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (12-29.5-101, C.R.S.) and have at least three (3) years' experience practicing Acupuncture at a rate of 520 hours per year; or at least two (2) years' experience practicing acupuncture at a rate of 520 hours per year AND at least one (1) year of experience working with individuals with spinal cord injuries or other long term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using acupuncture.
- c. Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (12-33-101, C.R.S.) and have at least three (3) years' experience practicing Chiropractic Care at a rate of 520 hours per year; or at least two (2) years' experience practicing Chiropractic Care at a rate of 520 hours per year AND at least one (1) year of experience working with individuals with spinal cord injuries or other long term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using chiropractic care.
- d. Massage Therapists shall be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (12-35.3-101, C.R.S.) and have at least three (3) years' experience practicing Massage Therapy at a rate of 520 hours per year; or at least two (2) years' experience practicing massage therapy at a rate of 520 hours per year AND at least (1) year of experience working with individuals with spinal cord injuries or other long term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using massage therapy.

2. Environmental Standards for Complementary and Integrative Health Services provided in an outpatient setting.

- a. Complementary and Integrative Health Providers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. They shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.
 - b. Policies shall be developed and procedures implemented for the effective control of insects, rodents, and other pests.
 - c. All wastes shall be disposed in compliance with local, state and federal laws.
 - d. A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.
 - e. Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.
 - f. Outpatient settings shall be constructed and maintained to ensure access and safety.
 - g. Outpatient settings shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.
3. Failure to comply with the requirements of this rule may result in the revocation of the Complementary and Integrative Health Provider certification.

8.517.11.D COMPLEMENTARY AND INTEGRATIVE HEALTH CARE PLAN

1. Complementary and Integrative Health Providers shall:
 - a. Guide the development of the Complementary and Integrative Health Care Plan in coordination with the client and/or client's representative.
 - b. Recommend the appropriate modality, amount, scope, and duration of the Complementary and Integrative Health Services within the established limits as listed at 8.517.11.B;
 - c. Recommend only services that are necessary and appropriate and will be rendered by the recommending Complementary and Integrative Health Provider.
2. The Complementary and Integrative Health Provider shall reassess the Complementary and Integrative Health Care Plan at least annually or more frequently as necessary. The reassessment shall include a visit with the client.
3. When recommending the use of Complementary and Integrative Health Services for the treatment of a condition or symptom related to the client's spinal cord injury, the Complementary and Integrative Health Provider should use evidence from published medical literature that demonstrates the effectiveness of the services for the treatment of the condition or symptom.

- a. Where no evidence exists, the Complementary and Integrative Health Provider shall use their field expertise to guide service recommendations.
 - b. If additional expertise is required the Complementary and Integrative Health Provider may; consult the Medical Director and/or consult other Complementary and Integrative Health service providers.
- 4. The Complementary and Integrative Health Care Plan shall be developed using Department prescribed form(s) or template(s).
- 6. The Complementary and Integrative Health Care Plan shall include at least the following:
 - a. A summary of the client's treatment history;
 - b. An assessment of the client's current medical conditions/needs.
 - c. The amount, scope, and duration of each recommended Complementary and Integrative Health Services and the expected outcomes.
 - d. The recommended schedule of services.

8.518 REPEALED EFFECTIVE SEPTEMBER 30, 2016

8.519 HOME AND COMMUNITY BASED SERVICES FOR CHILDREN WITH AUTISM WAIVER

8.519.1 DEFINITIONS

Assessment means a comprehensive and uniform process using the ULTC Instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, including ADLs and Instrumental Activities of Daily Living, health status and other factors relevant to determine the client's level of functioning. Assessment process includes collecting information from the client and appropriate collaterals pertaining to service needs, available resources, potential funding sources and includes supporting diagnostic information from a licensed medical professional.

Autism means the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests as set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000. No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000 is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

Benefits Utilization System (BUS) means the web based data system maintained by the Department for recording case management activities associated with Long Term Care (LTC) services.

Care Plan means the document used to identify the client's needs and sets forth the services to be provided to the client including the funding source, amount, scope, duration, frequency, provider of each service and the expected outcome or purpose of such services.

Case Management means the evaluation of functional eligibility and other activities which may include assessment, service plan development, service plan implementation and service monitoring, the evaluation of service effectiveness, and the periodic reassessment of such client's needs. Case Management activities may also include assistance in accessing waiver, State Plan, and other non-Medicaid services and resources and ensuring the right to a Fair Hearing.

Case Management Agency (CMA) means an agency contracted by the Department to furnish case management services to applicants and clients within a designated service area. CMAs may include Single Entry Point (SEP) agencies, Community Centered Boards (CCB), and private case management agencies.

Continued Stay Review (CSR) means a periodic face to face review of a client's condition and service needs performed in the client's residence, by a case manager to determine a client's continued eligibility for LTC services.

Cost Containment means the cost of providing care in the community is less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services, Long Term Home Health services and Home Care Allowance.

Department means the Department of Health Care Policy and Financing.

Functional Eligibility means an applicant or client meets the criteria for LTC services as determined by the Department's ULTC instrument.

Functional Needs Assessment means a component of the Assessment process which includes a comprehensive face-to-face evaluation using the ULTC Instrument to determine if the client meets the appropriate Level of Care (LOC).

Intake/Screening/Referral means the initial contact with an individual by the CMA and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services, referral to other programs or services and the need for the Assessment.

Lead Therapist means a qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.

Line Staff means a qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.

Plan of Correction (POC) means a written plan submitted to and approved by the Department or the Department's designee includes the specific remediation and timeline that will correct identified deficiencies.

Prior Authorization Request (PAR) means the department prescribed form to authorize the reimbursement for services.

Senior Therapist means the qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.

Standardized, Norm-Referenced Assessment means the most current version of an assessment tool that measures a child's adaptive functioning, including but not limited to self-help skills, expressive and receptive communication, and adaptive and maladaptive behaviors. Examples of appropriate assessment tools include but are not limited to: the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), Scales of Independent Behavior, Revised (SIB-R), and Adaptive Behavior Assessment System, Second Edition (ABAS-II).

State Plan Benefit means the benefits the state covers in the operation of its Medicaid program. The State Plan is submitted to and approved by the Centers for Medicare and Medicaid acting on behalf of the Secretary for Health and Human Services.

Uniform Long Term Care (ULTC) Instrument means the Department prescribed form used to determine Functional Eligibility and medical verification for LTC services

Utilization Review (UR) means a system for prospective, concurrent, and retrospective review of the necessity and appropriateness of the allocation of supports and services to ensure the proper and efficient administration of Medicaid Long Term Care benefits. UR may use the ULTC Instrument and other assessment instruments as indicated by the Department and/or its designee.

8.519.2 BENEFITS

8.519.2.A. Home and Community Based Services for Children with Autism (HCBS-CWA) benefits shall be provided within Cost Containment.

8.519.2.B. Behavioral therapies shall be provided in a group or individual setting.

8.519.2.C. Behavioral therapies shall only be a benefit if they are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means. Behavioral therapies may include:

1. Intensive developmental behavioral therapies specifically created to meet the client's needs including conditioning, biofeedback or reinforcement techniques.
2. Treatment goals that are consistent with building elementary verbal skills, teaching imitation, establishing appropriate toy play or interactive play with other children, teaching appropriate expression of emotions and behaviors, and where necessary, reducing self stimulation and aggressive behaviors.
3. One-on-one behavior therapy between a client and a therapist following a specific protocol established by the Lead Therapist. Therapy may be implemented by a Lead Therapist, Senior Therapist, or Line Staff.
4. Training or modeling for parents or a guardian so that the behavioral therapies can continue in the home. Training or modeling shall be:
 - a. Directed toward instruction on therapies and use of equipment specified in the Care Plan.
 - b. Carried out in the presence of and for the direct benefit of the client.

8.519.2.D. Benefits shall be limited to three years, either contiguous or intermittent with a one-year extension based on medical necessity as stated by the client's physician and upon approval by the Department.

8.519.2.E. The annual cost of benefits per client shall not exceed \$25,000 or available funds whichever is less.

8.519.3 NON-BENEFIT

8.519.3.A. Case Management shall not be a benefit of the HCBS-CWA waiver but shall be provided as an administrative activity through the CMA.

8.519.3.B. Speech therapy shall not be a benefit under behavior therapies.

8.519.4 CLIENT ELIGIBILITY

8.519.4.A. An eligible client shall:

1. Be determined financially eligible by the financial eligibility site in the county where the applicant resides.
2. Be determined to meet the definition of disability as defined by the Federal Social Security Administration.
3. Be at risk of institutionalization into an ICF/MR as determined by the Case Manager using the ULTC Instrument.
4. Be safely served in the community within Cost Containment as determined by the Case Manager.
5. Meet the target population criteria as follows:
 - a. Has a diagnosis of Autism as certified by a physician.
 - b. Has not yet reached six years of age.

8.519.4.B. A client shall receive at least one HCBS-CWA waiver benefit per month to maintain enrollment in the waiver. Case Management itself is not a benefit for purposes of satisfying the requirement to receive at least one benefit per month on the HCBS-CWA waiver.

8.519.4.C. A client who has not received at least one benefit on the HCBS-CWA waiver for a period of one month shall be discontinued from the waiver.

8.519.5 WAIT LIST

8.519.5.A. The number of clients who may be served through the waiver at any one time during a year shall be limited by the Department.

8.519.5.B. Applicants who are determined eligible for benefits under the HCBS-CWA waiver, who cannot be served within the Department established limit, shall be eligible for placement on a wait list maintained by the Department.

8.519.5.C. The Case Manager shall ensure the applicant meets all criteria as set forth in Section 8.519.4 prior to notifying the Department to place the applicant on the wait list.

8.519.5.D. The Case Manager shall enter the client's Assessment and Professional Medical Information Page data in the BUS and notify the Department by sending the client's enrollment information, utilizing the Department's approved form, to the Program Administrator

8.519.5.E. The score received from a standardized, norm-referenced assessment, shall be used to establish the order of an applicant's place on the wait list after November 1, 2013.

1. The case manager will confirm that the assessment score submitted by a client is from a standardized norm-referenced assessment tool.
2. If two clients have the same score, the date and time of the completed ULTC Instrument, as entered in the BUS, shall be used to establish the clients' order on the wait list.

8.519.5.F. Within five working days of notification from the Department that an opening for the HCBS-CWA waiver is available the CMA shall:

1. Reassess the applicant for functional level of care using the ULTC Instrument if more than 6 months has elapsed since the previous assessment.
2. Update the existing ULTC Instrument in the BUS if more than six months has elapsed since the date of the previous.
3. Reassess for the target population criteria.
4. Notify the Department of the applicant's eligibility status.

8.519.6 PROVIDER ELIGIBILITY

8.519.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CWA waiver, meet the responsibilities as set forth in Section 8.519.7 and enter into an agreement with the Department as set forth in 10 C.C.R. 2505-10, Section 8.130.

8.519.6.B. Providers shall enroll individually with the fiscal agent.

8.519.6.C. Providers shall be employed by a qualified Medicaid provider agency, clinic or hospital except for a Lead Therapist who may provide services independent from a Medicaid provider agency when the Lead Therapist employs the Senior Therapist and Line Staff.

8.519.6.D. Lead Therapists shall meet one of the following requirements:

1. Have a doctoral degree with a specialty in psychiatry, medicine or clinical psychology and be actively licensed by the state board of examiners. Have completed 400 hours of training and/or have direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.
2. Have a doctoral degree in one of the behavioral or health sciences and have completed 800 hours of specific training and/or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.
3. Have a Master's degree, or higher, in behavioral sciences and be nationally certified as a "Board Certified Behavior Analyst" or certified Relationship Development Intervention (RDI) consultant or certified by a similar nationally recognized organization.
4. Have a Master's degree or higher in one of the behavior or health sciences and certification as a School Psychologist; or licensed teacher with an endorsement of special education or early childhood special education; or licensed psychotherapy provider; or credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist) and have completed 1,000 hours of direct supervised training or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

8.519.6.E. The Lead Therapist shall assess the child and develop the treatment plan based on the child's individual needs. The Lead Therapist shall prescribe the amount, scope and duration of the therapy, make treatment adjustments and be responsible for treatment outcomes. The Lead Therapist shall be required to provide a written progress report for the case manager and the family every six months.

8.519.6.F. Senior Therapists shall meet one of the following requirements:

1. Have a Master's degree or higher in one of the behavior or health related sciences and have completed 1,000 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.
2. Have a bachelor's degree or higher in a human services field and have completed at least 2,000 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

8.519.6.G. The senior therapist shall provide ongoing supervision and implementation of the treatment plan. This includes the supervision of line staff, training of the families and conducting team meetings with the family, line staff and other providers to review the child's progress. The senior therapist shall provide documentation of the location of the agency that is providing services, the time spent and the team members who participated in the delivery of services.

8.519.6.H. Line Staff shall meet all of the following requirements:

1. Be at least 18 years of age
2. Have graduated from high school or earned a high school equivalency degree.
3. Have or acquire 20 hours or more of direct supervised experience billable under the direction of a Lead or a Senior Therapist, in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.
4. Demonstrate understanding of the services and outcomes for children with Autism as attested to by the Lead Therapist or Senior Therapist.
5. Have cleared the provider's background check at the time he/she is hired.

8.519.6.I. The line staff shall be trained directly by the lead and/or senior therapist. The senior therapist is responsible for the line staff supervision and shall work with the line staff to implement the treatment plan. All services provided by the line staff shall be under the direction of the senior therapist and shall be documented.

8.519.7 PROVIDER RESPONSIBILITIES

8.519.7.A. HCBS-CWA Providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining and terminating employees.

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2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section 19-3-304 C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statutes, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.
 - a. The Lead Therapist shall maintain a log of all complaints and critical incidents which shall include documentation of the resolution of the complaint or incident.
 - b. The Lead Therapist shall communicate any critical incident via e-mail or fax to the Department within one business day.
- 8.519.7.B CWA Providers shall:
1. Ensure a client is not discontinued or refused services unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.
 2. Ensure client records and documentation of services are made available at the request of the Case Manager.
 3. Ensure that adequate records are maintained.
 - a. Client records shall contain:
 - i. Name, address, phone number and other identifying information for the client and the client's parent(s) and/or legal guardian(s).
 - ii. Name, address and phone number of the CMA and the Case Manager.
 - iii. Name, address and phone number of the client's primary physician.
 - iv. Special health needs or conditions of the client.
 - v. Documentation of the specific services provided which includes:
 1. Name of the individual provider.
 2. The location for the delivery of services.
 3. Units of service.
 4. The date, month and year of services and, if applicable, the beginning and ending time of day.
 5. All Standardized norm-referenced assessments completed or obtained
 6. Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.

7. Documentation regarding supervision of benefits.
 8. Financial records for all claims, including documentation of services as set forth at 10 C.C. R. 2505-10, Section 8.040.02.
 - b. Personnel records for each employee shall contain:
 - i. Documentation of qualifications to provide behavioral therapies.
 - ii. Documentation of training.
 - iii. Documentation of supervision and performance evaluation.
 - iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.519.7.B.
 - v. A copy of the employee's job description.
 4. Conduct or obtain a recent norm-referenced assessment (no more than 30 days old) of each client upon entering the program, every six months while on the program, and upon exit of the program.
 - a. The provider shall provide a copy of the assessment results of each completed assessment to the case manager and the parents or guardian of the child.
 - b. The provider shall review the results of each assessment completed for a child and make necessary adjustments to the child's intervention plan accordingly.

8.519.8 CASE MANAGEMENT AGENCY ELIGIBILITY

- 8.519.8.A. In accordance with C.R.S. 25.5-6-804(5), A CMA shall enter into a contract with the Department to provide client Assessment, Case Management and Utilization Review.
- 8.519.8.B. The CMA shall have computer hardware and software, compatible with the Department's BUS, with capacity and capabilities as prescribed by the Department.
- 8.519.8.C. The CMA shall be certified annually in accordance with quality assurance standards and requirements set forth in 10 C.C.R. 2505-10, Section 8.079.2.
1. Certification of a CMA shall be based on a survey of each CMA's performance in the following areas:
 - a. Quality of the Case Management services provided by the CMA to the clients based on the client satisfaction survey.
 - b. Compliance with waiver requirements.
 - c. Performance of administrative functions, including Cost Containment, timely reporting, on-site visits to clients, community outreach and client monitoring.
 - d. Whether targeted populations are identified and served.
 - e. Financial accountability.
 - f. Retention of qualified personnel to perform the contracted duties.

2. The CMA shall receive denial, provisional approval or approval of certification based on the outcome of the certification survey.
 3. In the event that the CMA does not meet the quality assurance standards, the CMA may receive provisional approval for certification for a period not to exceed 60 days provided the deficiencies do not constitute a threat to the health and safety of the clients.
 - a. The CMA shall submit a Corrective Action Plan to address any deficiencies. Upon receipt and review of the Corrective Action Plan, provisional certification may be approved at the Department's discretion for a single additional 60 day period.
 - b. If the Corrective Action Plan is not implemented successfully within the 60 day period, the service area will be assigned to another Department Approved CMA.
 - c. The CMA may receive technical assistance from the Department to facilitate corrective action.
- 8.519.8.D. The Department or its designee shall conduct reviews of the CMA agency.

8.519.9 CMA RESPONSIBILITIES

- 8.519.9.A. The CMA shall, in a format and manner specified by the Department, be responsible for the collection and reporting of summary and client specific data including, but not limited, to information and referral services provided by the agency, waiver eligibility determination, financial eligibility determination, care planning, service authorization, fiscal accountability and utilization review.
- 8.519.9.B. The CMA shall maintain case records in accordance with Department requirements.
1. Case records shall be maintained for:
 - a. Individuals for whom the CMA completed an intake for HCBS-CWA.
 - b. Individuals who are HCBS-CWA clients.
 2. Case records shall contain:
 - a. Identifying information, including the client's Medicaid identification number and social security number.
 - b. Identifying information referencing the client's parent(s) and/or legal guardian(s).
 - c. A copy of the ULTC Instrument and the Professional Medical Information Page (PMIP).
 - d. Documentation of the date on which the client referral was first received and dates of all actions taken thereafter by the CMA.
 - e. Documentation of all Assessment and target population criteria outcomes.
 - f. Documentation of all Case Management activities, the monitoring of service delivery, and service effectiveness.
 - g. Documentation that all Department required forms have the required signatures .

3. The CMA shall protect the confidentiality of all applicants and recipient records in accordance with section 26-1-114, C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statutes, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.
 4. The CMA shall protect the confidentiality of all applicants and recipient records in accordance with and the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 C.F.R., Parts 160 and 164. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the federal privacy law, copyright 1996, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.
 5. The CMA shall obtain release of information forms from the client's parent(s) and/or legal guardian(s) which shall be signed, dated and renewed at least annually or when there is a change in benefit provider.
- 8.519.9.C. The CMA shall assure that each client's parent(s) and/or legal guardian(s):
1. Is fully informed of his/her rights and responsibilities.
 2. Participates in the development and approval of the Care Plan and is provided a completed copy.
 3. Is given a choice of service providers from qualified providers in the CMA district of his/her residence.
 4. Is fully informed of and given access to a uniform complaint system as defined by the Department.
- 8.519.9.D. At least annually, the CMA shall conduct a client satisfaction survey which consists of surveying a sample of clients selected by the Department to determine their level of satisfaction with services provided by the CMA.
1. The random sample of clients shall include ten clients or ten percent of the CMA's average monthly HCBS-CWA caseload, whichever is higher.
 2. If the CMA's average monthly HCBS-CWA caseload is less than ten clients, all clients shall be included in the survey.
 3. The client satisfaction survey shall be on a Department approved form.
 4. The results of the client satisfaction survey shall be made available to the Department.
- 8.519.9.E. The CMA shall not require clients to come to the agency's office to receive Assessments, Utilization Review services or Case Management services.
- 8.519.9.F. The CMA shall provide adequate staff to meet all service and administrative functions including:

1. The CMA shall have a system for recruiting, hiring, evaluating, and terminating employees that complies with all federal and state affirmative action and civil rights requirements.
2. The CMA shall employ at least one full time case manager.
3. The CMA shall have adequate support staff to maintain a computerized information system in accordance with the Department's requirements.
4. CMA staff shall attend training sessions as directed and/or provided by the Department at the Department's expense.
5. The CMA shall provide in-service and staff development training at the CMA's expense.
6. The supervisor and case manager shall meet minimum the following standards for education and/or experience:
 - a. The case manager shall have at least a bachelor's degree in one of the human behavioral science fields or nursing.
 - b. The supervisor shall meet all qualifications for a case manager and have a minimum of two years of experience in long term care.
 - c. The CMA may request a waiver of these requirements from the Department prior to employing an individual when the CMA has been unable to secure the services of a qualified individual. The waiver shall be granted approval at the discretion of the Department.

8.519.10. CMA SERVICE FUNCTIONS

- 8.519.10.A. The CMA shall complete the following activities as a part of its Intake/Screening/Referral function:
1. Evaluate inquiries and address accordingly.
 2. Determine the appropriateness of a referral for an Assessment.
 3. Provide information and referral to other agencies as needed.
 4. Obtain the applicant's parent(s)' and/or legal guardian(s)' signature on the ULTC Intake Form.
- 8.519.10.B. If a referral for HCBS-CWA waiver services is determined to be appropriate, the CMA shall complete the following activities as a part of its Assessment:
1. Initiate the ULTC Instrument within two working days of receiving a referral.
 2. Identify potential payment source(s), including the availability of private funding resources.
 3. Verify the applicant's financial eligibility status for Medicaid, or refer the applicant to the financial eligibility site in the applicant's county of residence to determine financial eligibility for Medicaid.

4. Notify the applicant's parent(s) and/or legal guardian(s) of his/her right to appeal adverse actions of the CMA, the Department, or contractors acting on behalf of the Department as set forth in 10 C.C.R. 2505-10, Section 8.057.
 5. Obtain diagnostic information supplied from the Professional Medical Information Page from the applicant's medical provider, physician or nurse.
 6. Determine the applicant's functional capacity during an Assessment through observation of the applicant and family in his/her residential setting.
 7. Determine the applicant's service needs, taking into consideration services available or already being received from all funding sources.
 8. Inform the applicant's parent(s) and/or legal guardian(s) of the right to choose enrollment in other HCBS waivers for which the applicant is qualified. Document on the Care Plan, the parent(s)' and/or legal guardian(s)' waiver selection preference.
 9. Maintain appropriate documentation for certification of waiver eligibility.
 10. Submit documentation, as determined by the Department, for authorization of services.
- 8.519.10.C. The CMA shall complete the following activities as a part of the Utilization Review function:
1. Log each ULTC form received and reviewed.
 2. Score the client using the ULTC Instrument within one business day from the date of the Case Manager's Assessment.
 3. Input an electronic copy of the Assessment on the BUS within 10 business days after completing the Assessment.
 4. Notify the applicant's parent(s) and/or legal guardian(s) of the outcome of the Assessment with the Notice of Services Status (LTC 803) Form including:
 - a. The Assessment outcome shall be based upon waiver requirements and the ULTC Instrument score and shall determine if a client is approved or denied for enrollment or continued stay in the waiver.
 - b. When the Assessment outcome is a denial for enrollment in the waiver, the CMA shall notify the applicant's parent(s) and/or legal guardian(s) in accordance with 10 C.C. R. 2505-10, Section 8.057.
 5. The CMA shall develop the Care Plan upon completion of the Assessment and prior to authorizing services. The CMA shall complete the Care Plan and all required paperwork within 15 business days upon eligibility determination. Care planning shall include, but not be limited to:
 - a. Identifying and documenting Care Plan goals made with the participation of the client's parent(s) and/or legal guardian(s).
 - b. Identifying and documenting services needed including the type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but not available.

- c. Documenting a client's parent(s)' and/or legal guardian(s)' selection of qualified providers.

8.519.10.D. The CMA shall complete a CSR of a client within 12 months of the initial Assessment or the previous CSR. The CSR shall be completed not more than three months before the end of the current certification period. A CSR shall be completed sooner if the client's condition changes.

- 1. A CSR shall include but not be limited to the following activities:
 - a. Obtain an update of the Professional Medical Information Page from the client's physician.
 - b. Assess a client's functional status face-to-face at the client's place of residence using the ULTC Instrument.
 - c. Update the Care Plan and provider contacts.
 - d. Evaluate service effectiveness, quality of care and appropriateness of services.
 - e. Verify continuing Medicaid financial and waiver eligibility.
 - f. Inform the client's Lead Therapist of any changes in the client's needs.
 - g. Refer the client to community resources as needed and develop resources for the client to the extent that the resource can be made available in the community.

8.519.10.E. The CMA shall authorize services

- 1. The CMA shall Submit the PAR to the Department or the Department's designees to approve the authorization of services and provider reimbursement.
- 2. The CMA shall be financially responsible for any services authorized which do not meet the requirements as set forth in Section 8.519 et. seq., or which are rendered by a provider due to the CMA's failure to timely notify the provider that the client is no longer eligible for services.

8.519.10.F The CMA shall provide on-going Case Management for a client as defined below:

- 1. On-going Case Management shall include, but not be limited to:
 - a. Review the Care Plan.
 - b. Contact the client's parent(s) and/or legal guardian(s) concerning the satisfaction with services provided.
 - c. Contact the service providers concerning their effectiveness and appropriateness regarding their service coordination.
 - d. Investigate complaints raised by the client's parent(s) and/or legal guardian(s) concerning the service providers.
 - e. Contact the appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client's parent(s) and/or legal guardian(s).

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- f. Resolve conflict or crisis related to the waiver benefit or Medicaid state plan service delivery, as needed.
 - g. Assess changes in the client's functioning, service effectiveness, service appropriateness and service cost-effectiveness.
 - h. Refer to community resources as needed.
 - 2. The CMA shall contact the client's parent(s) and/or legal guardian(s) at least monthly or more frequently as determined by the client's needs.
 - 3. The CMA shall review and update the ULTC Instrument and Care Plan, with the client's parent(s) and/or legal guardian(s) as required by a significant change in the client's condition. The review shall be conducted by telephone or at the client's place of residence, place of service or other appropriate setting as determined by the client's needs.
 - 4. The CMA shall contact the service providers to monitor service delivery at least every three months, as required by the client's needs or the specific service requirements.
 - 5. If the CMA suspects a client to be a victim of abuse, neglect or exploitation, the CMA shall immediately refer the client to the protective services section of the county department of social services in the client's county or residence and/or the local law enforcement agency.
 - 6. The CMA shall immediately report any information that indicates an overpayment, incorrect payment or misuse of any public assistance benefit to the Department. The CMA and case manager shall cooperate with the appropriate agency in any subsequent recovery process in accordance with the 10 C.C.R. 2505-10, Section 8.076.
 - 8.519.10.G. The CMA shall complete Denials and discontinuations.
 - 1. The CMA shall notify the client's parent(s) and/or legal guardian(s) within one working day of determining the client no longer meets waiver requirements.
 - 2. A client shall be notified of the denial/discontinuation by the CMA on the Department prescribed LTC 803 form if he/she is determined ineligible due to any of the following reasons:
 - a. The client no longer meets all of the criteria set forth at Sections 8.519.4.
 - b. The client exceeds the limitations set forth at Sections 8.519.2.E and 8.519.2.F.
 - c. The client's parent(s) and/or legal guardian(s) has twice in a 30 day consecutive period, refused to schedule an appointment for an Assessment or Case Management visit.
 - d. The client's parent(s) and/or legal guardian(s) has failed to keep three scheduled provider appointments in a 30 day period.
 - e. The client's parent(s) and/or legal guardian(s) fails to sign the Intake, Care Plan, Release of Information, or other forms as required.
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3. The CMA shall notify a client's parent(s) and/or legal guardian(s) of the denial or discontinuation of services using the Department prescribed advisement letter for reasons not related to enrollment criteria:
 - a. A client who moves out of Colorado shall be discontinued effective upon the day after the date of the move.
 - b. A client whose parent(s) and/or legal guardian(s) voluntarily withdraws the client from the waiver shall be discontinued effective upon the day after the date on which the request is documented, or the date on which the client enters a long term care institution or another HCBS waiver.
 4. The CMA shall not send notification when the denial or discontinuation is due to the death of the client. A client who dies shall be discontinued from the waiver, effective upon the day after the date of death.
 5. The case manager shall provide the client with appropriate referrals to other community resources, as needed, within one working day of discontinuation.
 6. The CMA shall notify all providers on the Care Plan within one working day of discontinuation.
 7. The CMA shall notify the financial eligibility site within one working day after the denial or discontinuation.
 8. If a case is discontinued before an approved HCBS prior authorization request (PAR) has expired, the case manager shall submit to the Department, within five working days of discontinuation, a copy of the current PAR form on which the end date is adjusted and highlighted. The reason for discontinuation shall be noted on the form.
- 8.519.10.H. et seq. The CMA shall participate in the appeals process per 10 C.C.R. 2505-10, Section 8.057
1. The CMA shall provide information to an applicant's parent(s) and/or legal guardian(s) regarding appeal rights when he/she applies for the waiver or whenever such information is requested, whether or not an adverse action has been taken by the CMA.
 2. The CMA shall attend an appeals hearing to defend a determination of enrollment, denial or discontinuation.
 3. The CMA shall not attend an appeal hearing for a denial or discontinuation based on financial eligibility unless subpoenaed or requested by the Department.

8.519.11 PRIOR AUTHORIZATION REQUESTS

- 8.519.11.A The CMA shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CWA waiver.
1. All units of service requested shall be listed on the Care Plan form.
 2. The first date for which services can be authorized shall be the later of any 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 ULTC Instrument.
 - c. The date on which the client's parent(s) and/or legal guardian(s) signs the Care Plan form or Intake form, as prescribed by the Department, agreeing to receive services.
- 3. The PAR shall not cover a period of time longer than that indicated on the ULTC Instrument.
- 4. The CMA shall submit a revised PAR if a change in the Care Plan results in a change in type or amount of services.
 - a. The revised Care Plan shall list the services being changed and state the reason for the change. Services on the revised Care Plan form, plus all services on the original Care Plan, shall be entered on the revised PAR.
 - b. Revisions to the Care Plan requested by providers after the end date on a PAR shall be disapproved.
- 5. A revised PAR shall not be submitted if services on the Care Plan are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.
- 6. If services are decreased without the client's parent(s) and/or legal guardian(s) agreement, the case manager shall notify the client's parent(s) and/or legal guardian(s) of the adverse action and of appeal rights using the LTC 803 form in accordance with the 10 day advance notice period.

8.519.11 REIMBURSEMENT

- 8.519.11.A. Reimbursement for CMA functions shall be determined by the number of clients served and the type of services provided and is subject to the availability of funds.
- 8.519.11.B. Providers shall be reimbursed at the lower of:
 - 1. Submitted charges; or
 - 2. A fee schedule as determined by the Department.

8.520 HOME HEALTH SERVICES

8.520.1. Definitions

- 8.520.1.A. Activities of Daily Living (ADL) means daily tasks that are required to maintain a client's health, and include eating, bathing, dressing, toileting, grooming, transferring, walking, and continence. When a client is unable to perform these activities independently, skilled or unskilled providers may be required for the client's needs.
- 8.520.1.B. Acute Medical Condition means a medical condition which has a rapid onset and short duration. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.
- 8.520.1.C. Alternative Care Facility means an assisted living residence licensed by the Colorado Department of Public Health and Environment (CDPHE), and certified by the Department of Health Care Policy and Financing (Department) to provide Assisted Living Care Services and protective oversight to clients.
- 8.520.1.D. Behavioral Intervention means techniques, therapies, and methods used to modify or minimize aggressive (verbal/physical), combative, destructive, disruptive, repetitious, resistive, self-injurious, or other inappropriate behaviors outlined on the CMS-485 Plan of Care (defined below). Behavioral interventions exclude frequent verbal redirection or additional time to transition or complete a task, which are part of the general assessment of the client's needs.
- 8.520.1.E. Care Coordination means the deliberate organization of client care activities between two or more participants (including the client) for the appropriate delivery of health care and health support services, and organization of personnel and resources needed for required client care activities.
- 8.520.1.F. Certified Nurse Aide Assignment Form means the form used by the Home Health Agency to list the duties to be performed by the Certified Nurse Aide (CNA) at each visit.
- 8.520.1.G. Department means the Colorado Department of Health Care Policy and Financing which is designated as the single State Medicaid agency for Colorado, or any divisions or sub-units within that agency.
- 8.520.1.H. Designee means the entity that has been contracted by the Department to review for the Medical Necessity and appropriateness of the requested services, including Home Health prior authorization requests (PARs). Designees may include case management entities such as Single Entry Points or Community Centered Boards who manage waiver eligibility and review.
- 8.520.1.I. Home Care Agency means an entity which provides Home Health or Personal Care Services. When referred to in this rule without a 'Class A' or 'Class B' designation, the term encompasses both types of agencies.
- 8.520.1.J. Home Health Agency means an agency that is licensed as a Class A Home Care Agency in Colorado, and is certified to provide skilled care services to Medicare and Medicaid eligible clients. Agencies shall hold active and current Medicare and Medicaid provider IDs to provide services to Medicaid clients.
- 8.520.1.K. Home Health Services means those services listed at Section 8.520.5, Service Types.

8.520.1.L. Home Health Telehealth means the remote monitoring of clinical data transmitted through electronic information processing technologies, from the client to the home health provider which meet HIPAA compliance standards.

8.520.1.M. Intermittent means visits that have a distinct start time and stop time, and are task oriented with the goal of meeting a client's specific needs for that visit.

8.520.1.N. Ordering Physician means the client's primary care physician, or other physician specialist. For clients in a hospital or nursing facility, the Ordering Physician is the physician responsible for writing discharge orders until such time as the client is discharged. This definition may include an alternate physician authorized by the Ordering Physician to care for the client in the Ordering Physician's absence.

8.520.1.O. Personal Care Worker means an employee of a licensed Home Care Agency who has completed the required training to provide Personal Care Services, or who has verified experience providing Personal Care Services for clients. A Personal Care Worker shall not perform tasks that are considered skilled CNA services.

8.520.1.P. Place of Residence means where the client lives. Includes temporary accommodations, homeless shelters or other locations for clients who are homeless or have no permanent residence.

8.520.1.Q. Plan of Care means a coordinated plan developed by the Home Health Agency, as ordered by the Ordering Physician for provision of services to a client at his or her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements. This shall be written on the CMS-485 ("485") or a document that is identical in content, specific to the discipline completing the plan of care.

8.520.1.R. Pro Re Nata (PRN) means as needed.

8.520.1.S. Protective Oversight means maintaining an awareness of the general whereabouts of a client. Also includes monitoring the client's activity so that a caregiver has the ability to intervene and supervise the safety, nutrition, medication, and other care needs of the client.

8.520.2. Client Eligibility

8.520.2.A. Home Health Services are available to all Medicaid clients and to all Old Age Pension Program clients, as defined at Section 8.940, when all program and service requirements in this rule are met.

8.520.2.B. Medicaid clients aged 18 and over shall meet the Level of Care Screening Guidelines for Long-Term Care Services at Section 8.401, to be eligible for Long-Term Home Health Services, as set forth at Section 8.520.4.C.2.

8.520.3. Provider Eligibility

8.520.3.A. Services must be provided by a Medicare and Medicaid-certified Home Health Agency.

8.520.3.B. All Home Health Services providers shall comply with the rules and regulations set forth by the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, the Colorado Department of Regulatory Agencies, the Centers for Medicare and Medicaid Services, and the Colorado Department of Labor and Employment.

8.520.3.C. Provider Agency Requirements

1. A Home Health Agency must:
 - a. Be certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act;
 - b. Be a Colorado Medicaid enrolled provider;
 - c. Maintain liability insurance for the minimum amount set annually by the Department; and
 - d. Be licensed by the State of Colorado as a Class A Home Care Agency in good standing.
2. Home Health Agencies which perform procedures in the client's home that are considered waived clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 shall possess a certificate of waiver from the Centers for Medicare and Medicaid Services (CMS) or its Designee.
3. Home Health Agencies shall regularly review the Medicaid rules, 10 CCR 2505-10. The Home Health Agency shall make access to these rules available to all staff.
4. A Home Health Agency cannot discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal. The Home Health Agency must provide notice of at least thirty days to the client, or the client's legal guardian.
5. In the event a Home Health Agency is ceasing operations, or ceasing services to Medicaid clients, the agency will provide notice to the Department's Home Health Policy Specialist of at least thirty days prior to the end of operations.

8.520.4. Covered Services

8.520.4.A. Home Health Services are covered under Medicaid only when all of the following are met:

1. Services are Medically Necessary as defined in Section 8.076.1.8;
2. Services are provided under a Plan of Care as defined at Section 8.520.1., Definitions;
3. Services are provided on an Intermittent basis, as defined at Section 8.520.1., Definitions;
4. The client meets one of the following:
 - a. The only alternative to Home Health Services is hospitalization or emergency room care; or
 - b. Client medical records indicate that medically necessary services should be provided in the client's place of residence, instead of an outpatient setting, according to one or more of the following guidelines:
 - i) The client, due to illness, injury or disability, is unable to travel to an outpatient setting for the needed service;

- ii) Based on the client's illness, injury, or disability, travel to an outpatient setting for the needed service would create a medical hardship for the client;
 - iii) Travel to an outpatient setting for the needed service is contraindicated by a documented medical diagnosis;
 - iv) Travel to an outpatient setting for the needed service would interfere with the effectiveness of the service; or
 - v) The client's medical diagnosis requires teaching which is most effectively accomplished in the client's place of residence on a short-term basis.
5. The client is unable to perform the health care tasks for him or herself, and no unpaid family/caregiver is able and willing to perform the tasks; and
6. Covered service types are those listed in Service Types, Section 8.520.5.

8.520.4.B. Place of Service

1. Services shall be provided in the client's place of residence or one of the following places of service:
- a. Assisted Living Facilities (ALFs);
 - b. Alternative Care Facilities (ACFs);
 - c. Group Residential Services and Supports (GRSS) including host homes, apartments or homes where three or fewer clients reside. Services shall not duplicate those that are the contracted responsibility of the GRSS;
 - d. Individual Residential Services and Supports (IRSS) including host homes, apartments or homes where three or fewer clients reside. Services shall not duplicate those that are the contracted responsibility of the IRSS; or
 - e. Hotels, or similar temporary accommodations while traveling, will be considered the temporary place of residence for purposes of this rule.
 - f. Nothing in this section should be read to prohibit a client from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

8.520.4.C. Service Categories

1. Acute Home Health Services
- a. Acute Home Health Services are covered for clients who experience an acute health care need that requires Home Health Services.
 - b. Acute Home Health Services are provided for 60 or fewer calendar days or until the acute medical condition is resolved, whichever comes first.

- c. Acute Home Health Services are provided for the treatment of the following acute medical conditions/episodes:
 - i) Infectious disease;
 - ii) Pneumonia;
 - iii) New diagnosis of a life-altering disease;
 - iv) Post-heart attack or stroke;
 - v) Care related to post-surgical recovery;
 - vi) Post-hospital care provided as follow-up care for medical conditions that required hospitalization, including neonatal disorders;
 - vii) Post-nursing home care, when the nursing home care was provided primarily for rehabilitation following hospitalization and the medical condition is likely to resolve or stabilize to the point where the client will no longer need Home Health Services within 60 days following initiation of Home Health Services;
 - viii) Complications of pregnancy or postpartum recovery; or
 - iv) Individuals who experience an acute incident related to a chronic disease may be treated under the acute home health benefit. Specific information on the acute incident shall be documented in the record.
- d. A client may receive additional periods of acute Home Health Services when at least 10 days have elapsed since the client's discharge from an acute home health episode and one of the following circumstances occurs:
 - i) The client has a change in medical condition that necessitates acute Home Health Services;
 - ii) New onset of a chronic medical condition; or
 - iii) Treatment needed for a new acute medical condition or episode.
- e. Nursing visits provided solely for the purpose of assessment or teaching are covered only during the acute period under the following guidelines:
 - i) An initial assessment visit ordered by a physician is covered for determination of whether ongoing nursing or CNA care is needed. Nursing visits for the sole purpose of assessing a client for recertification of Home Health Services shall not be reimbursed if the client receives only CNA services;
 - ii) The visit instructs the client or client's family member/caregiver in providing safe and effective care that would normally be provided by a skilled home health provider; or
 - iii) The visit supervises the client or client's family member/caregiver to verify and document that they are competent in providing the needed task.

- f. Acute Home Health Services may be provided to clients who receive Health Maintenance tasks through In-Home Supports and Services (IHSS) or Consumer Directed Attendant Supports and Services (CDASS).
 - g. GRSS group home residents may receive acute Home Health Services.
 - h. If the acute home health client is hospitalized for planned or unplanned services for 10 or more calendar days, the Home Health Agency may close the client's acute home health episode and start a new acute home health episode when the client is discharged.
 - i. Acute Care Home Health Limitations:
 - i) A new period of acute Home Health Services shall not be used for continuation of treatment from a prior Acute Home Health episode. New Acute Episodes must be utilized for a new or worsening condition.
 - ii) A client who is receiving either Long-Term Home Health Services or HCBS waiver services may receive acute Home Health Services only if the client experiences an event listed in subpart c. as an acute incident, which is separate from the standard needs of the client and makes acute Home Health Services necessary.
 - iii) If a client's acute medical condition resolves prior to 60 calendar days from onset, the client shall be discharged from acute home health or transitioned to the client's normal Long-Term Home Health services.
- 2. Long-Term Home Health Services
 - a. Long-term Home Health Services are covered for clients who have long-term chronic needs requiring ongoing Home Health Services.
 - b. Long-term Home Health Services may be provided to clients who receive health maintenance tasks through IHSS.
 - c. Long-term Home Health Services may not be provided to clients who receive health maintenance tasks through CDASS.
 - d. Long-term Home Health Services are provided:
 - i) Following the 60th calendar day for acute home health clients who require additional services to meet treatment goals or to be safely discharged from Home Health Services;
 - ii) On the first day of Home Health Services for clients with well documented chronic needs when the client does not require an acute home health care transition period; or
 - iii) Continuation of ongoing long-term home health Plan of Care.
 - e. Long-Term Home Health Limitations:
 - i) Clients aged 20 and younger may obtain long-term home health physical therapy, occupational therapy, and speech therapy services when Medically Necessary and when:

- 1) Therapy services will be more effective if provided in the home setting; or
 - 2) Outpatient therapy would create a hardship for the client.
 - ii) Clients aged 21 and older who continue to require physical therapy, occupational therapy, and speech therapy services after the initial acute home health period may only obtain such long-term services in an outpatient setting.
 - iii) Clients admitted to long-term Home Health Services through the HCBS waiver program shall meet level of care criteria to qualify for long-term Home Health Services.
 - iv) Long-term Home Health Services may be provided in GRSS group home settings, when the GRSS provider agency reimburses the Home Health Agency directly for these Home Health Services. Long-term Home Health Service provision in GRSS group homes is not reimbursable through the State Plan.
3. Long-Term with Acute Episode Home Health:
 - a. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.
 - b. Long-term with acute episode home health is covered if the client is receiving long-term home health services and requires treatment for an acute episode as defined in section 8.520.4.C.1.

8.520.5. Service Types

8.520.5.A. Nursing Services

1. Standard Nursing Visit
 - a. Those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards;
 - b. Those skilled nursing services provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws;
 - c. Standard Nursing Visits include but are not limited to:
 - i. 1st medication box fill (medication pre-pouring) of the week;
 - ii. 1st visit of the day; the remaining visits shall utilize brief nursing units as appropriate;
 - iii. Insertion or replacement of indwelling urinary catheters;
 - iv. Colostomy and ileostomy stoma care; excluding care performed by clients;
 - v. Treatment of decubitus ulcers (stage 2 or greater);

- vi. Treatment of widespread, infected or draining skin disorders;
- vii. Wounds that require sterile dressing changes;
- viii. Visits for foot care;
- ix. Nasopharyngeal, tracheostomy aspiration or suctioning, ventilator care;
- x. Bolus or continuous Levin tube and gastrostomy (G-tube) feedings, when formula/feeding needs to be prepared or more than 1 can of prepared formula is needed per bolus feeding per visit, ONLY when there is not an able or willing caregiver; and
- xi. Complex Wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

2. Brief Nursing Visits

- a. Brief nursing visits for established long-term home health clients who require multiple visits per day for uncomplicated skilled tasks that can be completed in a shorter or brief visit (excluding the first regular nursing visit of the day)
- b. Brief Nursing Visits include, but are not limited to:
 - i) Consecutive visits for two or more clients who reside in the same location and are seen by the same Home Health Agency nurse, excluding the first visit of the day;
 - ii) Intramuscular, intradermal and subcutaneous injections (including insulin) when required multiple times daily, excluding the first visit of the day;
 - iii) Insulin administration: if the sole reason for a daily visit or multiple visits per day, the first visit of the week is to be treated as a standard nursing visit and all other visits of the week are to be treated as brief nursing visits.
 - iv) Additional visits beyond the first visit of the day where simple wound care dressings are the sole reason for the visit;
 - v) Additional visits beyond the first visit of the day where catheter irrigation is the sole reason for the visit;
 - vi) Additional visits beyond the first visit of the day where external catheterization, or catheter care is the sole purpose for the visit;
 - vii) Bolus Levin or G-tube feedings of one can of prepared formula excluding the first visit of the day, ONLY when there is no willing or able caregiver and it is the sole purpose of the visit;
 - viii) Medication box refills or changes following the first medication pre-pouring of the week;

- ix) Other non-complex nursing tasks as deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate; or
 - x) A combination of uncomplicated tasks when deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate.
 - c. Ongoing assessment shall be billed as brief nursing visits unless the client experiences a change in status requiring a standard visit. If a standard nursing visit is required for the assessment, the agency shall provide documentation supporting the need on the PAR form and on the Plan of Care for the Department or its Designee.
- 3. PRN Nursing Visits
 - a. May be standard nursing visits or brief nursing visits; and
 - b. Shall include specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.
- 4. Nursing Service Limitations
 - a. Nursing assessment visits are not covered if provided solely to open or recertify the case for CNA services, physical, occupational, or speech therapy.
 - b. Nursing visits solely for recertifying a client are not covered.
 - c. Nursing visits that are scheduled solely for CNA supervision are not covered.
 - d. Family member/caregivers, who meet the requirements to provide nursing services and are nurses credentialed by, and in active status with the Department of Regulatory Agencies, may be employed by the Home Health Agency to provide nursing services to a client, but may only be reimbursed for services that exceed the usual responsibilities of the Family Member/Caregiver.
 - e. PRN nursing visits may be requested as standard nursing visits or brief nursing visits and shall include a physician's order with specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.
 - f. Nursing visits are not reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Behavioral Health Organization. Nursing visits for mentally ill clients are reimbursed under Home Health Services for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.
 - g. Medicaid does not reimburse for two nurses during one visit except when two nurses are required to perform a procedure. For this exception, the provider may bill for two visits, or for all units for both nurses. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.
 - h. Nursing visits provided solely for the purpose of assessing or teaching are reimbursed by the Department only in the following circumstances:

- i) Nursing visits solely for the purpose of assessing the client or teaching the client or the client's unpaid family member/caregiver are not reimbursed unless the care is acute home health or long-term home health with acute episode, per Section 8.520.3, or the care is for extreme instability of a chronic medical condition under long-term home health, per Section 8.520.3. Long-term home health nursing visits for the sole purpose of assessing or teaching are not covered.
- ii) When an initial assessment visit is ordered by a physician and there is a reasonable expectation that ongoing nursing or CNA care may be needed. Initial nursing assessment visits cannot be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.
- iii) When a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the client or the client's unpaid family member/caregiver how to perform the task, the visit is not considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the client or unpaid family member/caregiver performing the task to verify that the task is being performed correctly is considered a visit that is solely for the purpose of assessing and teaching and is not covered.
- iv) Nursing visits provided solely for the purpose of assessment or teaching cannot exceed the frequency that is justified by the client's documented medical condition and symptoms. Assessment visits may continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific medical conditions or symptoms which are not stable or not resolved. Teaching visits may be as frequent as necessary, up to the maximum reimbursement limits, to teach the client or the client's unpaid family member/caregiver, and may continue only as long as needed to demonstrate understanding or to perform care, or until it is determined that the client or unpaid family member/caregiver is unable to learn or to perform the skill being taught. The visit in which the nurse determines that there is no longer a need for assessment or teaching shall be reimbursed if it is the last visit provided solely for assessment or teaching.
- v) Nursing visits provided solely for the purpose of assessment or teaching are not reimbursed if the client is capable of self-assessment and of contacting the physician as needed, and if the client's medical records do not justify a need for client teaching beyond that already provided by the hospital or attending physician, as determined and documented on the initial Home Health assessment.
- vi) Nursing visits provided solely for the purpose of assessment or teaching cannot be reimbursed if there is an available and willing unpaid family member/caregiver who is capable of assessing the client's medical condition and needs and contacting the physician as needed; and if the client's medical records do not justify a need for teaching of the client's unpaid family member/caregiver beyond the teaching already provided by the hospital or attending physician, as determined and documented on the initial Home Health assessment.

- i. Nursing visits provided solely for the purpose of providing foot care are reimbursed by Medicaid only if the client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the client or unpaid family member/caregiver is not able or willing to provide the foot care.
- j. Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit. The clinical record shall indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for foot care to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:
 - i) Absent (not palpable) posterior tibial pulse;
 - ii) Absent (not palpable) dorsalis pedis pulse;
 - iii) Three of the advanced trophic changes:
 - 1) Hair growth (decrease or absence),
 - 2) Nail changes (thickening),
 - 3) Pigmentary changes (discoloration),
 - 4) Skin texture (thin, shiny), or
 - 5) Skin color (rubor or redness);
 - iv) Claudication (limping, lameness);
 - v) Temperature changes (cold feet);
 - vi) Edema;
 - vii) Parasthesia; or
 - viii) Burning.
- k. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers are reimbursed only if:
 - i) The client is not living in a licensed Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at C.R.S. 25-1.5-301;
 - ii) The client is not physically or mentally capable of pre-pouring medications or has a medical history of non-compliance with taking medications if they are not pre-poured;
 - iii) The client has no unpaid family member/caregiver who is willing or able to pre-pour the medications for the client; and

- iv) There is documentation in the client's chart that the client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular client.
- l. The unit of reimbursement for nursing services is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

8.520.5.B. Certified Nurse Aide Services

1. CNA services may be provided when a nurse or therapist determines that an eligible client requires the skilled services of a qualified CNA, as such services are defined in this section 8.520.5.B.13
2. CNA tasks shall not duplicate waiver services or the client's residential agreement (such as an ALF, IRSS, GRSS, or other Medicaid reimbursed Residence, or adult day care setting).
3. Skilled care shall only be provided by a CNA when a client is unable to independently complete one or more ADLs. Skilled CNA services shall not be reimbursed for tasks or services that are the contracted responsibilities of an ALF, IRSS, GRSS or other Medicaid reimbursed Residence.
4. Before providing any services, all CNAs shall be trained and certified according to Federal Medicare regulations, and all CNA services shall be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR 484.36. Title 42 of the Code of Federal Regulations, Part 484.36 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.
5. If the client receiving CNA services also requires and receives skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist shall make on-site supervisory visits to the client's home no less frequently than every two weeks.
6. If the client receiving CNA services does not require skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse shall make on-site supervisory visits to the client's home no less frequently than every 60 days. Each supervisory visit shall occur while the CNA is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the CNA services, and cannot be billed to Medicaid as nursing visits.
7. Registered nurses and physical, occupational and speech therapists supervising CNAs shall comply with applicable state laws governing their respective professions.
8. CNA services can include personal care and homemaking tasks if such tasks are completed during the skilled care visit and are defined below:

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- a. Personal care or homemaking services which are directly related to and secondary to skilled care are considered part of the skilled care task, and are not further reimbursed. For clients who are also eligible for HCBS personal care and homemaker services, the units spent on personal care and homemaker services may not be billed as CNA services.
 - b. Nurse aide tasks performed by a CNA pursuant to the nurse aide scope of practice defined by the State Board of Nursing, but does not include those tasks that are allowed as personal care, at Section 8.535, PEDIATRIC PERSONAL CARE.
 - c. Personal care means those tasks which are allowed as personal care at Section 8.535, PEDIATRIC PERSONAL CARE, and Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE.
 - d. Homemaking means those tasks allowed as homemaking tasks at Section 8.490, HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES.
9. CNA services solely for the purpose of behavior management are not a benefit under Medicaid Home Health, because behavior management is outside the nurse aide scope of practice.
10. The usual frequency of all tasks is as ordered by the Ordering Physician on the Plan of Care unless otherwise noted.
11. The Home Health Agency shall document the decline in medical condition or the need for all medically necessary skilled tasks.
12. Skilled Certified Nurse Aide Tasks
- a. Ambulation
 - i) Task includes: Walking or moving from place to place with or without assistive device.
 - ii) Ambulation is a skilled task when:
 - 1) Client is unable to assist or direct care;
 - 2) Hands on assistance is required for safe ambulation and client is unable to maintain balance or to bear weight reliably; or
 - 3) Client has not been deemed independent with assistive devices ordered by a qualified physician.
 - iii) Special Considerations: Ambulation shall not be a sole reason for a CNA visit.
 - b. Bathing/Showering
 - i) Task includes either:

- 1) Preparation for bath or shower, checking water temperature; assisting client into bath or shower; applying soap and shampoo; rinsing off, towel drying; and all transfers and ambulation related to bathing; all hair care, pericare and skin care provided in conjunction with bathing; or
- 2) Bed bath or sponge bath.
- ii) The usual frequency of this task shall be up to one time daily.
- iii) Bathing/Showering is a skilled task when either:
 - 1) Open wound(s), stoma(s), broken skin or active chronic skin disorder(s) are present; or
 - 2) Client is unable to maintain balance or to bear weight due to illness, injury, disability, a history of falls, temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.
- iv) Special Considerations:
 - 1) Additional baths may be warranted for treatment and shall be documented by physician order and Plan of Care.
 - 2) A second person may be staffed when required to safely bathe the client.
 - 3) Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.

c. Bladder Care

- i) Task includes:
 - 1) Assistance with toilet, commode, bedpan, urinal, or diaper;
 - 2) Transfers, skin care, ambulation and positioning related to bladder care; and
 - 3) Emptying and rinsing commode or bedpan after each use.
- ii) Bladder Care concludes when the client is returned to a pre-urination state.
- iii) Bladder Care is a skilled task when either:
 - 1) Client is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days); or
 - 2) Client requires skilled skin care associated with bladder care or client has been assessed as having a high and ongoing risk for skin breakdown.

- d. Bowel Care
 - i) Task includes:
 - 1) Changing and cleaning incontinent client, or hands on assistance with toileting; and
 - 2) Returning client to pre-bowel movement status, which includes transfers, skin care, ambulation and positioning related to bowel care.
 - ii) Bowel care is a skilled task when either:
 - 1) Client is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days) is present; or
 - 2) Client requires skilled skin care associated with bowel care or client has been assessed as having a high and ongoing risk for skin breakdown.
- e. Bowel Program
 - i) Skilled Task includes:
 - 1) Administering bowel program as ordered by the client's qualified physician, including digital stimulation, administering enemas, suppositories, and returning client to pre-bowel program status; or
 - 2) Care of a colostomy or ileostomy, which includes emptying the ostomy bag, changing the ostomy bag and skin care at the site of the ostomy and returning the client to pre-procedure status.
 - ii) Special Considerations
 - 1) To perform the task, the client must have a relatively stable or predictable bowel program/condition and a qualified physician deems that the CNA is competent to provide the client-specific program.
 - 2) Use of digital stimulation and over-the-counter suppositories or over-the-counter enema (not to exceed 120ml) only when the CNA demonstrates competence in the Home Health Agency's Policies & Procedures for the task. (Agencies may choose to delegate this task to the CNA.)
- f. Catheter Care
 - i) Task includes:
 - 1) Care of external, Foley and Suprapubic catheters;
 - 2) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care;

- 3) Emptying catheter bags; and
 - 4) Transfers, skin care, ambulation and positioning related to the catheter care.
 - ii) The usual frequency of this task shall not exceed two times daily.
 - iii) Catheter care is a skilled task when either:
 - 1) Emptying catheter collection bags (indwelling or external) includes a need to record and report the client's urinary output to the client's nurse; or
 - 2) The indwelling catheter tubing needs to be opened for any reason and the client is unable to do so independently.
 - iv) Special Considerations: Catheter care shall not be the sole purpose of the CNA visit.
- g. Dressing
 - i) Task includes:
 - 1) Dressing and undressing with ordinary clothing, including pantyhose or socks and shoes;
 - 2) Placement and removal of braces and splints; and
 - 3) All transfers and positioning related to dressing and undressing.
 - ii) The usual frequency of this task shall not exceed twice daily.
 - iii) Dressing is a skilled task when:
 - 1) Client requires assistance with the application of anti-embolic or pressure stockings and placement of braces or splints that can be obtained only with a prescription from a qualified physician; or
 - 2) Client is unable to assist or direct care; or
 - 3) Client experiences a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.
 - iv) Special Considerations: Hand-over-hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.
- h. Exercise/Range of Motion (ROM)
 - i) Task includes: ROM and other exercise programs prescribed by a therapist or qualified physician, and only when the client is not receiving exercise/ROM from a therapist or a doctor on the same day.

- ii) Exercise/Range of Motion (ROM) is a skilled task when: The exercise/ROM, including passive ROM, is prescribed by a qualified physician and the CNA has demonstrated competency.
 - iii) Special Considerations: The Home Health Agency shall ensure the CNA is trained in the exercise program. The Home Health Agency shall maintain the exercise program documentation in the client record and it shall be evaluated/renewed by the qualified physician or therapist with each Plan of Care.
- i. Feeding
 - i) Task includes:
 - 1) Ensuring food is the proper temperature, cutting food into bite-size pieces, and ensuring the food is proper consistency;
 - 2) Placing food in client's mouth; and
 - 3) Gastric tube (g-tube) formula preparation, verifying placement and patency of tube, administering tube feeding and flushing tube following feeding if the Home Health Agency and supervising nurse deem the CNA competent.
 - ii) The usual frequency of this task shall not exceed three times daily.
 - iii) Feeding is a skilled task when:
 - 1) Client is unable to communicate verbally, non-verbally or through other means;
 - 2) Client is unable to be positioned upright;
 - 3) Client is on a modified texture diet;
 - 4) Client has a physiological or neurogenic chewing or swallowing problem;
 - 5) Client is on mechanical ventilation;
 - 6) Client requires oral suctioning;
 - 7) A structural issue (such as cleft palate) or other documented swallowing issues are present; or
 - 8) Client has a history of aspirating food.
 - iv) Special Considerations:
 - 1) There shall be a documented decline in medical condition or an ongoing need documented in the client's record.
 - 2) A Home Health Agency may allow a CNA to perform a syringe feeding and tube feeding if the CNA is deemed competent.

- j. Hygiene – Hair Care/Grooming
 - i) Task includes: Shampooing, conditioning, drying, and combing.
 - ii) Task does not include perming, hair coloring, or other extensive styling including, but not limited to, updos, placement of box braids or other elaborate braiding or placing hair extensions.
 - iii) Task may be completed during skilled bath/shower.
 - iv) The usual frequency of this task shall not exceed twice daily.
 - v) Hygiene – Hair Care/Grooming is a skilled task when:
 - 1) Client is unable to complete task independently;
 - 2) Client requires shampoo/conditioner that is prescribed by a qualified physician and dispensed by a pharmacy; or
 - 3) Client has open wound(s) or stoma(s) on the head.
 - vi) Special Considerations:
 - 1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.
 - 2) Styling of hair is never considered a skilled task.
- k. Hygiene – Mouth Care
 - i) Task includes:
 - 1) Brushing teeth;
 - 2) Flossing;
 - 3) Use of mouthwash;
 - 4) Denture care;
 - 5) Swabbing (toothette); or
 - 6) Oral suctioning.
 - ii) The usual frequency of this task is up to three times daily.
 - iii) Hygiene – Mouth Care is a skilled task when:
 - 1) Client is unconscious;
 - 2) Client has difficulty swallowing;
 - 3) Client is at risk for choking and aspiration;

- 4) Client requires oral suctioning;
 - 5) Client has decreased oral sensitivity or hypersensitivity; or
 - 6) Client is on medications that increase the risk of bleeding of the mouth.
 - iv) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.
- I. Hygiene – Nail Care
- i) Task includes: Soaking, filing, and nail trimming.
 - ii) The usual frequency of this task shall not exceed one time weekly.
 - iii) Hygiene – Nail Care is a skilled task when:
 - 1) The client has a medical condition that involves peripheral circulatory problems or loss of sensation;
 - 2) The client is at risk for bleeding; or
 - 3) The client is at high risk for injury secondary to the nail care.
 - iv) Nail Care shall only be completed by a CNA who has been deemed competent in nail care by the Home Health Agency for this population.
 - v) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.
- m. Hygiene – Shaving
- i) Task includes: shaving of face, legs and underarms with manual or electric razor.
 - ii) The usual frequency of this task shall not exceed once daily; task may be completed with bathing/showering.
 - iii) Hygiene – Shaving is a skilled task when:
 - 1) The client has a medical condition involving peripheral circulatory problems;
 - 2) The client has a medical condition involving loss of sensation;
 - 3) The client has an illness or takes medications that are associated with a high risk for bleeding; or
 - 4) The client has broken skin at/near shaving site or a chronic active skin condition.

- iv) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.
- n. Meal Preparation
 - i) Task includes:
 - 1) Preparation of food, ensuring food is proper consistency based on the client's ability to swallow food safely; or
 - 2) Formula preparation.
 - ii) The usual frequency of this task shall not exceed three times daily.
 - iii) Meal Preparation is a skilled task when: Client's diet requires either nurse oversight to administer correctly, or meals requiring a modified consistency.
- o. Medication Reminders
 - i) Task includes:
 - 1) Providing client reminders that it is time to take medications;
 - 2) Handing of pre-filled medication box to client;
 - 3) Handing of labeled medication bottle to client; or
 - 4) Opening of prefilled box or labeled medication bottle for client.
 - ii) This task may be completed by a CNA during the course of a visit, but cannot be the sole purpose of the visit.
 - iii) A CNA may not perform this task, unless the CNA meets the DORA-approved CNA-MED certification, at 3 C.C.R. § 716-1 Chapter 19 Section 6. If the CNA does not meet the DORA certifications, the CNA may still ask if the client has taken medications and may replace oxygen tubing and may set oxygen to ordered flow rate.
 - iv) Special Considerations: CNAs shall not administer medications without obtaining the CNA-MED certification from the DORA approved course. 3 C.C.R. 716-1 Chapter 19 Section 6. If the CNA has obtained this certification, the CNA may perform pre-pouring and medication administration within the scope of CNA-MED certification at 3 C.C.R. 716-1 Chapter 19 Section 3.
- p. Positioning
 - i) Task includes:
 - 1) Moving the client from the starting position to a new position while maintaining proper body alignment and support to a client's extremities, and avoiding skin breakdown; and

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- 2) Placing any padding required to maintain proper alignment.
 - 3) Positioning as a stand-alone task excludes positioning that is completed in conjunction with other Activities of Daily Living.
 - ii) Positioning is a skilled task when:
 - 1) Client is unable to communicate verbally, non-verbally or through other means;
 - 2) Client is not able to perform this task independently due to illness, injury or disability; or
 - 3) Client has temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.
 - 4) Positioning the client requires adjusting the client's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a qualified physician.
 - iii) Special Considerations:
 - 1) The Home Health Agency shall coordinate visits to ensure that effective scheduling is utilized for skilled Intermittent visits.
 - 2) Positioning cannot be the sole reason for a visit.
 - q. Skin Care
 - i) Task includes:
 - 1) Applying lotion or other skin care product, when it is not performed in conjunction with bathing or toileting tasks.
 - ii) Skin care is a skilled task when:
 - 1) Client requires additional skin care that is prescribed by a qualified physician or dispensed by a pharmacy;
 - 2) Client has broken skin; or
 - 3) Client has a wound(s) or active skin disorder and is unable to apply product independently due to illness, injury or disability.
 - iii) Special Considerations:
 - 1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the client in Activities of Daily Living when there has been a change in the client's medical condition that has increased the client's ability to perform this task.
 - 2) This task may be included with positioning.

r. Transfers

i) Task includes:

- 1) Moving the client from one location to another in a safe manner.

ii) It is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care or other CNA task.

iii) Transfers is a skilled task when:

- 1) Client is unable to communicate verbally, non-verbally or through other means;
- 2) Client is not able to perform this task independently due to fragility of illness, injury or disability;
- 3) Client has a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability;
- 4) Client lacks the strength and stability to stand or bear weight reliably;
- 5) Client is not deemed independent in the use of assistive devices or Durable Medical Equipment that has been ordered by a qualified physician; or
- 6) Client requires a mechanical lift for safe transfers. In order to transfer clients via a mechanical lift, the CNA shall be deemed competent in the particular mechanical lift used by the client.

iv) Special Considerations:

- 1) A second person may be used when required to safely transfer the client.
- 2) Transfers may be completed with or without mechanical assistance.
- 3) Any unskilled task which requires a skilled transfer shall be considered a skilled task.

s. Vital Signs Monitoring

i) Task includes:

- 1) Taking and reporting the temperature, pulse, blood pressure and respiratory rate of the client.
- 2) Blood glucose testing and pulse oximetry readings only when the CNA has been deemed competent in these measures.

ii) Vital sign monitoring is always a skilled task.

iii) Special Considerations:

- 1) Shall only be performed when delegated by the client's nurse. Vital signs monitoring cannot be the sole purpose of the CNA visit.
- 2) Vital signs shall be taken only as ordered by the client's nurse or the Plan of Care and shall be reported to the nurse in a timely manner.
- 3) The CNA shall not provide any intervention without the nurse's direction, and may only perform interventions that are within the CNA practice act and for which the CNA has demonstrated competency.

13. Certified Nurse Aide Limitations

- a. In accordance with the Colorado Nurse Aide Practice Act, a CNA shall only provide services that have been ordered on the Home Health Plan of Care as written by the Ordering Physician.
- b. CNAs assist with Activities of Daily Living and cannot perform a visit for the purpose of behavior modification. When a client's disabilities involve behavioral manifestations, the CNA shall follow all applicable behavioral plans and refrain from actions that will escalate or upset the client. In such cases the guardian, case manager, behavioral professional or mental health professional shall provide clear direction to the agency for the provision of care. The CNA shall not perform Behavioral Interventions, beyond those listed in c. of this section.
- c. If the client has a behavior plan created by a behavior or mental health professional, the CNA shall follow this plan within their scope and training to the same extent that a family client or paraprofessional in a school would be expected to follow the plan.
- d. When an agency allows a CNA to perform skilled tasks that require competency or delegation, the agency shall have policies and procedures regarding its process for determining the competency of the CNA. All competency testing and documentation related to the CNA shall be retained in the CNA's personnel file.
- e. CNA services can only be ordered when the task is outside of the usual responsibilities of the client's family member/caregiver.
- f. Cuing or hand over hand assistance to complete Activities of Daily Living is not considered a skilled task, however, the agency may provide up to 90 days of care to teach a client Activities of Daily Living when the client is able to learn to perform the tasks independently. Cuing or hand over hand care that exceeds 90 days, or is provided when the client has not had a change in ability to complete self-care techniques, is not covered. If continued cuing or hand over hand assistance is required after 90 days, this task shall be transferred to a Personal Care Worker or other competent individual who can continue the task.
- g. Personal care needs or skilled CNA services that are the contracted responsibility of an ALF, GRSS or IRSS are not reimbursable as a separate Medicaid Home Health Service.

- h. Family members/caregivers who meet all relevant requirements may be employed as a client's CNA, but may only provide services that are identified in this benefit coverage standard as skilled CNA services and that exceed the usual responsibilities of the family member/caregiver. Family member/caregiver CNAs must meet all CNA requirements.
 - i. All CNAs who provide Home Health Services shall be subject to all requirements set forth by the policies of the Home Health Agency, and all applicable State and Federal laws.
 - j. When a CNA holds other licensure(s) or certification(s), but is employed as or functions as a CNA, the services are reimbursed at the CNA rate for services.
 - k. CNA visits cannot be approved for, nor can extended units be billed for the sole purpose of completing personal care, homemaking tasks or instrumental Activities of Daily Living.
 - l. Personal care needs for clients ages twenty years and under, not directly related to a skilled care task, shall be addressed through Section 8.535, PEDIATRIC PERSONAL CARE.
 - m. Homemaker Services provided as directly related tasks secondary to skilled care during a skilled CNA visit shall be limited to the permanent living space of the client. Such services are limited to tasks that benefit the client and are not for the primary benefit of other persons living in the home.
 - n. Nursing or CNA visits, or requests for extended visits, for the sole purpose of Protective Oversight are not reimbursable by Medicaid.
 - o. CNA services for the sole purpose of providing personal care or homemaking services are not covered.
 - p. The Department does not reimburse for services provided by two CNAs to the same client at the same time, except when two CNAs are required for transfers, there are no other persons available to assist, and the reason why adaptive equipment cannot be used instead is documented in the Plan of Care. For this exception, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.
 - q. The basic unit of reimbursement for CNA services is up to one hour. A unit of time that is less than fifteen minutes cannot be reimbursed as a basic unit.
 - r. For CNA visits that last longer than one hour, extended units may be billed in addition to the basic unit. Extended units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes cannot be reimbursed as an extended unit.
14. Certified Nurse Aide (CNA) Supervision
- a. CNA services shall be supervised by a registered nurse, by the physical therapist, or when appropriate, the speech therapist or occupational therapist depending on the specific Home Health Services the client is receiving.

- b. If the client receiving CNA services is also receiving skilled nursing care or physical therapy or occupational therapy, the supervising registered nurse or therapist shall make supervisory visits to the client's home no less frequently than every 14 days. The CNA does not have to be present for every supervisory visit. However, the registered nurse, or the therapist shall make on-site supervisory visits to observe the CNA in the client's home at least every 60 days.
- c. If the client is only receiving CNA services, the supervising registered nurse or the physical therapist shall make on-site supervisory visits to observe the CNA in the client's home at least every 60 days.
- d. The Department does not reimburse for any visit made solely for the purpose of supervising the CNA.
- e. For all clients expected to require CNA services for at least a year, during supervisory visits the supervising nurse shall:
 - i) Obtain input from the client, or the client's designated representative into the Certified Nurse Aide Assignment Form, including all CNA tasks to be performed during each scheduled time period.
 - ii) Document details, duties, and obligations on the Certified Nurse Aide Assignment Form.
 - iii) Assure the Certified Nurse Aide Assignment Form contains information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information pertinent to the care to be provided by the CNA.
 - iv) Obtain the client's, or the client's authorized representative's, per section 8.520.7.E.1, signature on the form, and provide a copy to the client at the beginning of services, and at least once per year thereafter. A new copy of the Written Notice of Home Care Consumer Rights form, per section 8.520.7.E.1, shall also be provided at these times.
 - v) Explain the rights listed in the patient's rights form whenever the Certified Nurse Aide Assignment Form is renegotiated and rewritten.
 - vi) For purposes of complying with this requirement, once per year means a date within one year of the prior certification.
- 15. If a client does not meet the factors that make a task skilled, as outlined in Section 8.520.5., the client may be eligible to receive those services as unskilled personal care through Section 8.535, PEDIATRIC PERSONAL CARE, or Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE.

8.520.5.C. Therapy Services

- 1. Therapies are only covered:
 - a. In acute home health care; or
 - b. Clients 20 years of age or younger may receive long-term home health therapy when services are medically necessary.

- c. When the client's Ordering Physician prescribes therapy services, and the therapist is responsible for evaluating the client and creating a treatment plan with exercises in accordance with practice guidelines.
- 2. The therapist shall teach the client, the client's family member/caregiver and other clients of the Home Health care team to perform the exercises as necessary for an optimal outcome.
- 3. When the therapy Plan of Care includes devices and equipment, the therapist shall assist the client in initiating or writing the request for equipment and train the client on the use of the equipment.
- 4. Home Health Agencies shall only provide physical, occupational, or speech therapy services when:
 - a. Improvement of functioning is expected or continuing;
 - b. The therapy assists in overcoming developmental problems;
 - c. Therapy visits are necessary to prevent deterioration;
 - d. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration, and to teach CNAs or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; or
 - e. Therapy visits are indicated to assess the safety or optimal functioning of the client in the home, or to train in the use of equipment used in implementation of the therapy Plan of Care.
- 5. Physical Therapy
 - a. Physical therapy includes any evaluations and treatments allowed under state law at C.R.S. 12- 41-101 through 130, which are applicable to the home setting.
 - b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.
 - c. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation in Medicare, at 42 CFR 484.4; and who meets all requirements under state law. Title 42 of the Code of Federal Regulations, Part 484.4 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

- i) Physical therapy assistants (PTA) can render Home Health therapy but shall practice under the supervision of a registered physical therapist.
- d. For clients who do not require skilled nursing care, the physical therapist may open the case and establish the Plan of Care.
- e. Physical therapists are responsible for completing client assessments related to various physical skills and functional abilities.
- f. Physical therapy includes evaluations and treatments allowed under state law and is available to all acute home health clients and pediatric long-term Home Health clients. Therapy plans and assessments shall contain the therapy services requested; the specific procedures and modalities to be used, including amount, duration, and frequency; and specific goals of therapy service provision.
- g. Limitations
 - i) Physical therapy for clients age 21 or older is not covered for acute care needs when treatment becomes focused on maintenance, and no further functional progress is apparent or expected to occur.
 - ii) Physical therapy is not a benefit for adult long-term home health clients. Clients 20 years of age or younger may receive Long-Term Home Health therapy services when services are medically necessary.
 - iii) Clients ages 21 and older who continue to require therapy after the acute home health period may obtain long-term therapy services in an outpatient setting. Clients shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.
 - iv) Clients 20 years of age or younger may obtain therapy services for maintenance care through acute home health and through long-term home health.
 - v) Physical therapy visits for the sole purpose of providing massage or ultrasound are not covered.
 - vi) Medicaid does not reimburse for two physical therapists during one visit.
 - vii) The unit of reimbursement for physical therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.
- 6. Occupational Therapy
 - a. Occupational therapy includes evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.
 - b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request and shall assist in training the client on the use of the equipment.

- c. Treatment shall be provided by or under the supervision of a registered occupational therapist who meets the qualifications prescribed by federal regulations for participation under applicable federal and state laws, including Medicare requirements at 42 CFR 484.4.
 - i) Occupational therapy assistants (OTA) can render Home Health therapy but shall practice under the supervision of a registered occupational therapist.
- d. For clients who do not require skilled nursing care, the occupational therapist may open the case and establish the Plan of Care.
- e. Occupational therapy includes only evaluations and treatments that are allowed under state law for occupational therapists.
- f. Occupational therapists shall create a plan and perform assessments which state the specific therapy services requested, the specific procedures and modalities to be used, the amount, duration, frequency, and the goals of the therapy service provision.
- g. Limitations
 - i) Occupational therapy for clients age 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance and no further functional progress is apparent or expected to occur.
 - ii) Occupational therapy is not a benefit for adult long-term home health clients.
 - iii) Clients ages 21 and older who continue to require therapy after the acute home health period may only obtain long-term therapy services in an outpatient setting.
 - iv) Clients shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.
 - v) Clients 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.
 - vi) Medicaid does not reimburse for two occupational therapists during one visit.
 - vii) The unit of reimbursement for occupational therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.
- 7. Speech Therapy
 - a. Speech therapy services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.

- b. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.
- c. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4.
- d. For clients who do not require skilled nursing care, the speech therapist may open the case and establish the Medicaid plan of care.
- e. The speech/language pathologist shall state the specific therapy services requested, the specific procedures and modalities to be used, as well as the amount, duration, frequency and specific goals of therapy services on the Plan of Care.
- f. Limitations
 - i) Speech therapy for clients age 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance and no further functional progress is apparent or expected to occur.
 - ii) Clients cannot be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.
 - iii) Speech therapy is not a benefit for adult long-term home health clients.
 - iv) Treatment of speech and language delays is only covered when associated with a chronic medical condition, neurological disorder, acute illness, injury, or congenital issue.
 - v) Clients 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.
 - vi) Medicaid does not reimburse for two speech therapists during one visit.
 - vii) The unit of reimbursement for speech therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

8.520.5.D. Home Health Telehealth Services

- 1. The Home Health Agency shall create policies and procedures for the use and maintenance of the monitoring equipment and the process of telehealth monitoring. This service shall be used to monitor the client and manage the client's care, and shall include all of the following elements:
 - a. The client's designated registered nurse or licensed practical nurse, consistent with state law, shall review all data collected within 24 hours of receipt of the ordered transmission, or in cases where the data is received after business hours, on the first business day following receipt of the data;

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- b. The client's designated nurse shall oversee all planned interventions;
 - c. Client-specific parameters and protocols defined by the agency staff and the client's authorizing physician or podiatrist; and
 - d. Documentation of the clinical data in the client's chart and a summary of response activities, if needed.
 - i) The nurse assessing the clinical data shall sign and date all documentation; and
 - ii) Documentation shall include the health care data that was transmitted and the services or activities that are recommended based on the data.
 - 2. The Home Health Agency shall provide monitoring equipment that possesses the capability to measure any changes in the monitored diagnoses, and meets all of the following requirements:
 - a. FDA certified or UL listed, and used according to the manufacturer's instructions;
 - b. Maintained in good repair and free from safety hazards; and
 - c. Sanitized before installation in a client's home.
 - 3. Home Health Telehealth services are covered for clients receiving Home Health Services, when all of the following requirements are met:
 - a. Client receives services from a home health provider for at least one of the following diagnoses:
 - i) Congestive Heart Failure;
 - ii) Chronic Obstructive Pulmonary Disease;
 - iii) Asthma;
 - iv) Diabetes;
 - v) Pneumonia; or
 - vi) Other diagnosis or medical condition deemed eligible by the Department or its Designee.
 - b. Client requires ongoing and frequent monitoring, minimum of five times weekly, to manage their qualifying diagnosis as defined and ordered by a physician or podiatrist;
 - c. Client has demonstrated a need for ongoing monitoring as evidenced by:
 - i) Having been hospitalized or admitted to an emergency room two or more times in the last twelve months for medical conditions related to the qualifying diagnosis;
 - ii) If the client has received Home Health Services for less than six months, the client was hospitalized at least once in the last three months;

- iii) An acute exacerbation of a qualifying diagnosis that requires telehealth monitoring; or
 - iv) New onset of a qualifying disease that requires ongoing monitoring to manage the client in their residence.
 - d. Client or caregiver misses no more than five transmissions of the provider and agency prescribed monitoring events in a thirty-day period; and
 - e. Client's home environment has the necessary connections to transmit the telehealth data to the agency and has space to set up and use the equipment as prescribed.
- 4. The Home Health Agency shall make at least one home health nursing visit every 14 days to a client using Home Health Telehealth services.
- 5. The Home Health Agency shall develop agency-specific criteria for assessment of the need for Home Health Telehealth services, to include patient selection criteria, home environment compatibility, and patient competency. The agency shall complete these assessment forms prior to the submission of the enrollment application and they shall be kept on file at the agency.
- 6. The client and/or caregiver shall comply with the telehealth monitoring as ordered by the qualifying physician.
- 7. Limitations:
 - a. Clients who are unable to comply with the ordered telehealth monitoring shall be disenrolled from the services.
 - b. Services billed prior to obtaining approval to enroll a client into Home Health Telehealth services by the Department or its Designee are not a covered benefit.
 - c. The unit of reimbursement for Home Health Telehealth is one calendar day.
 - i) The Home Health Agency may bill one initial installation unit per client lifetime when the monitoring equipment is installed in the home.
 - ii) The Home Health Agency may bill the daily rate for each day the telehealth monitoring equipment is used to monitor and manage the client's care.
 - d. Once per lifetime per client, a Home Health Agency may bill for the installation of the Home Health Telehealth equipment.

8.520.6 Supplies

8.520.6.A. Reimbursement for routine supplies is included in the reimbursement for nursing, CNA, physical therapy, occupational therapy, and speech therapy services. Routine supplies are supplies that are customarily used during the course of home care visits. These are standard supplies utilized by the Home Health Agency staff, and not designated for a specific client.

8.520.6.B. Non-routine supplies may be a covered benefit when approved by the Department or its Designee.

8.520.6.C. Limitations

1. A Home Health Agency cannot require a client to purchase or provide supplies that are necessary to carry out the client's Plan of Care.
2. A client may opt to provide his or her own supplies.

8.520.7. Documentation

8.520.7.A. Home Health Agencies shall have written policies regarding nurse delegation.

8.520.7.B. Home Health Agencies shall have written policies regarding maintenance of clients' durable medical equipment, and make full disclosure of these policies to all clients with durable medical equipment in the home. The Home Health Agency shall provide such disclosure to the client at the time of intake.

8.520.7.C. Home Health Agencies shall have written policies regarding procedures for communicating with case managers of clients who are also enrolled in HCBS programs. Such policies shall include, at a minimum:

1. How agencies will inform case managers that services are being provided or are being changed; and
2. Procedures for sending copies of Plans of Care if requested by case managers. These policies shall be developed with input from case managers.

8.520.7.D. Plan of Care Requirements

1. The client's Ordering Physician shall order Home Health Services in writing, as part of a written Plan of Care. The written Plan of Care shall be updated every 60 calendar days but need not be provided to the Department or its Designee unless the client's status has changed significantly, a new PAR is needed, or if requested by the Department or its Designee.
2. The initial assessment or continuation of care assessments shall be completed by a registered nurse, or by a physical therapist, occupational therapist or speech therapist when no skilled nursing needs are required. The assessment shall be utilized to develop the Plan of Care with provider input and oversight. The written Plan of Care and associated documentation shall be used to complete the CMS-485 (or a document that is identical in content) and shall include:
 - a. Identification of the attending physician;
 - b. Physician orders;
 - c. Identification of the specific diagnoses, including the primary diagnosis, for which Medicaid Home Health Services are requested.
 - d. The specific circumstances, client medical condition(s) or situation(s) that require services to be provided in the client's residence rather than in a physician's office, clinic or other outpatient setting including the availability of natural supports and the client's living situation;
 - e. A complete list of supplements, and medications, both prescription and over the counter, along with the dose, the frequency, and the means by which the medication is taken;

- f. A complete list of the client's allergies;
- g. A list of all non-routine durable medical equipment used by the client;
- h. A list of precautions or safety measures in place for the client, as well as functional limitations or activities permitted by the client's qualified physician;
- i. A behavioral plan when applicable. Physical Behavioral Interventions, such as restraints, shall not be included in the home health Plan of Care;
- j. A notation regarding the client's physician-ordered dietary (nutritional) requirements and restrictions, any special considerations, other restrictions or nutritional supplements;
- k. The Home Health Agency shall indicate a comprehensive list of the amount, frequency, and expected duration of provider visits for each discipline ordered by the client's physician, including:
 - i) The specific duties, treatments and tasks to be performed during each visit;
 - ii) All services and treatments to be provided on the Plan of Care;
 - 1) Treatment plans for physical therapy, occupational therapy and speech therapy may be completed on a form designed specifically for therapy Plans of Care; and
 - iii) Specific situations and circumstances that require a PRN visit, if applicable.
- l. Current clinical summary of the client's health status, including mental status, and a brief statement regarding homebound status of the client;
- m. The client's prognosis, goals, rehabilitation potential and where applicable, the client's specific discharge plan;
 - i) If the client's illness, injury or disability is not expected to improve, or discharge is not anticipated, the agency is not required to document a discharge plan;
 - ii) The client's medical record shall include the reason that no discharge plan is present;
- n. The attending physician shall approve the Plan of Care with a dated signature. If an electronic signature is used, the agency shall document that an electronic signature was used and shall keep a copy of the physician's physical signature on file;
- o. Brief statement regarding the client's support network including the availability of the client's family member/caregiver and if applicable, information on why the client's family member/caregiver is unable or unwilling to provide the care the client requires; and
- p. Other relevant information related to the client's need for Home Health care.

3. A new Plan of Care shall be completed every 60 calendar days while the client is receiving Home Health Services. The Plan of Care shall include a statement of review by the physician every 60 days.
4. Home Health Agencies shall send new Plans of Care and other documentation as requested by the Department or its Designee.

8.520.7.E. Additional Required Client Chart Documentation

1. A signed copy of the Written Notice of Home Care Consumer Rights as required by the Department and at 42 CFR 484.10. Title 42 of the Code of Federal Regulations, Part 484.10 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;
2. Evidence of a face-to-face visit with the client's referring provider, or other appropriate provider, as required at 42 CFR 440.70. Title 42 of the Code of Federal Regulations, Part 440.70 (2016) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;
3. A signed and dated copy of the Agency Disclosure Form as required by the Department, with requirements at 42 CFR 484.12. Title 42 of the Code of Federal Regulations, Part 484.12 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;
4. Dates of the most recent hospitalization or nursing facility stay. If the most recent stay was within the last 90 days, reason for the stay (diagnoses), length of stay, summary of treatment, date and place discharged to shall be included in the clinical summary or update;
5. The expected health outcomes, which may include functional outcomes;
6. An emergency plan including the safety measures that will be implemented to protect against injury;
7. A specific order from the client's qualified physician for all PRN visits utilized;

8. Clear documentation of skilled and non-skilled services to be provided to the client with documentation that the client or client's family member/caregiver agrees with the Plan of Care;
9. Accurate and clear clinical notes or visit summaries from each discipline for each visit that include the client's response to treatments and services completed during the visit. Summaries shall be signed and dated by the person who provided the service. If an electronic signature is used, the agency shall document that an electronic signature was used and keep a copy of the physical signature on file;
10. Documented evidence of Care Coordination with the client's other providers;
11. When the client is receiving additional services (skilled or unskilled) evidence of Care Coordination between the other services shall be documented and include an explanation of how the requested Home Health Services do not overlap with these additional services;
12. A plan for how the agency will cover client services (via family member/caregiver or other agency staff) if inclement weather or other unforeseen incident prevents agency staff from delivering the Home Health care ordered by the qualified physician; and
13. If foot or wound care is ordered for the client, the Home Health Agency shall ensure the signs and symptoms of the disease process/medical condition that requires foot or wound care by a nurse are clearly and specifically documented in the clinical record. The Home Health Agency shall ensure the clinical record includes an assessment of the foot or feet, or wound, and physical and clinical findings consistent with the diagnosis, and the need for foot or wound care to be provided by a nurse.

8.520.8 Prior Authorization

8.520.8.A. General Requirements

1. Approval of the PAR does not guarantee payment by Medicaid.
2. The client and the HHA shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations.
3. Medicaid is always the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to only bill for Medicaid approved services to Medicare or other third party insurance prior to billing Medicaid.
 - a. Exceptions to this include Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP) and the following services that are not a skilled Medicare benefit (CNA services only, OT services only, Med-box pre-pouring and routine lab draws).

8.520.8.B. Acute Home Health

1. Acute Home Health Services do not require prior authorization. This includes episodes of acute home health for long-term home health clients.

2. If a client receiving long-term Home Health Services experiences an acute care event that necessitates moving the client to an acute home health episode, the agency shall notify the Department or its Designee that the client is moving from long-term home health to acute Home Health Services.
3. If the client's acute home health needs resolve prior to 60 calendar days, the Home Health Agency shall discharge the client, or submit a PAR for long-term Home Health Services if the client is eligible.
 - a. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 9 calendar days or less, the Home Health Agency shall resume the client's care under the current acute home health Plan of Care.
 - b. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 10 calendar days or more, the Home Health Agency may start a new Acute Home Health episode when the client returns to the Home Health Agency.
 - c. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within 10 working days of the beginning and within 10 working days of the end of the acute care episode.

8.520.8.C. Long-Term Home Health

1. Long-term Home Health Services require prior authorization under Section 8.017.E.
2. When an agency accepts an HCBS waiver client to long-term Home Health Services, the Home Health Agency shall contact the client's case management agency to inform the case manager of the client's need for Home Health Services.
3. The complete formal written PAR shall include:
 - a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;
 - b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services;
 - c. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance;
 - d. Any other medical information which will document the medical necessity for the Home Health Services;

- e. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;
 - f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the client's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and
 - g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.
 - h. Long Term Home Health Services for clients 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.
- 4. Authorization time frames:
 - a. PARs shall be submitted for, and may be approved for up to a one year period.
 - b. The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.
 - c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the CMS-485.
- 5. The PAR shall not be backdated to a date prior to the 'from' date of the CMS-485.
- 6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding clients:
 - a. PAR Approval: If services requested are in compliance with Medicaid rules are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.
 - b. PAR Denial:
 - i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (e.g, the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.
 - ii) When denied, services shall be approved for 15 additional days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

- c. Interim Services: Services provided during the period between the provider's submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.

8.520.8.D. EPSDT Services

1. Home Health Services beyond those allowed in Section 8.520.5, for clients ages 0 through 20, shall be reviewed for medical necessity under the EPSDT requirement, as defined at Section 8.280.1.
2. Home Health Services beyond those in Section 8.520.5, which are provided under the Home Health benefit due to medical necessity, cannot include services that are available under other Colorado Medicaid benefits for which the client is eligible, including, but not limited to, Private Duty Nursing, Section 8.540; HCBS Personal Care, Section 8.489; Pediatric Personal Care, Section 8.535; School Health and Related Services, Section 8.290, or Outpatient Therapies, Section 8.200.3.A.6, Section 8.200.5 and Section 8.200.3.D Exceptions may be made if EPSDT Home Health Services will be more cost-effective, provided that client safety is assured. Such exceptions shall, in no way, be construed as mandating the delegation of nursing tasks.
3. PARs for EPSDT home health shall be submitted and reviewed as outlined in Section 8.520.8, including all documentation outlined in Section 8.520.8, and any other medical information which will document the medical necessity for the EPSDT Home Health Services. The Plan of Care shall include the place of service for each home health visit.

8.520.8.E. Home Health Telehealth Services

1. Home Health Telehealth services require prior authorization.
2. The Home Health Telehealth PAR shall include all of the following:
 - a. A completed enrollment form;
 - b. An order for telehealth monitoring signed and dated by the Ordering Physician or podiatrist;
 - c. A Plan of Care, which includes nursing and therapy assessments for clients. Telehealth monitoring shall be included on the CMS-485 form, or a form that contains identical information to the CMS-485, and all applicable forms shall be complete; and
 - d. For ongoing telehealth, the agency shall include documentation on how telehealth data has been used to manage the client's care, if the client has been using Home Health Telehealth services.

8.520.9 Reimbursement

8.520.9.A. Rates of Reimbursement: Payment for Home Health Services is the lower of the billed charges or the maximum unit rate of reimbursement.

1. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed the daily maximum as designated by the Department and in alignment with the Legislative Budget.

2. The maximum daily reimbursement includes reimbursement for nursing visits, home health CNA visits, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.”

8.520.9.B. Special Reimbursement Conditions

1. Total reimbursement by the Department combined with third party liability and Medicare crossover claims shall not exceed Medicaid rates.
2. When Home Health Agencies provide Home Health Services in accordance with these regulations to clients who receive Home and Community Based Services for the Developmentally Disabled (HCBS-DD), the Home Health Agency is reimbursed:
 - a. Under normal procedures for home health reimbursement if the client resides in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID), or in IRSS host homes and settings; or
 - b. By the group home provider, if the client resides in a GRSS, because the provider has already received Medicaid funding for the Home Health Services and is responsible for payment to the Home Health Agency.
3. Acute Home Health Services for Medicaid HMO clients are the responsibility of the Medicaid HMO, including clients who are also HCBS recipients.
4. Services for a dual eligible client shall be submitted first to Medicare for reimbursement. All Medicare requirements shall be met and administrative processes exhausted prior to any dual eligible client’s claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except for the specific services listed in Section 8.520.0.E.4.a below for clients which meet the criteria listed in Section 8.520.9.E.4.b below.
 - a. A Home Health Agency may bill only Medicaid without first billing Medicare if both of the following are true:
 - i) The services below are the only services on the claim:
 - 1) Pre-pouring of medications;
 - 2) CNA services;
 - 3) Occupational therapy services when provided as the sole skilled service; or
 - 4) Routine laboratory draw services.
 - ii) The following conditions apply:
 - 1) The client is stable;
 - 2) The client is not experiencing an acute episode; and
 - 3) The client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

- b. The Home Health Agency shall maintain clear documentation in the client's record of the conditions and services that are billed to Medicaid without first billing Medicare.
 - c. A Home Health Change of Care Notice or Advance Beneficiary Notice of Non-Coverage shall be filled out as prescribed by Medicare.
- 5. Services for a dually eligible long-term home health client who has an acute episode shall be submitted first to Medicare for reimbursement. Medicaid may be billed if payment is denied by Medicare as a non-covered benefit and the service is a Medicaid benefit, or when the service meets the criteria listed in Section 8.520.9.E.4 above.
- 6. If both Medicare and Medicaid reimburse for the same visit or service provided to a client in the same episode, the reimbursement is considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.
 - a. Home Health Agencies shall return any payment made by Medicaid for such visit or service to the Department within sixty (60) calendar days of receipt of the duplicate payment.

8.520.9.C. Reimbursement for Supplies

- 1. A Home Health Agency shall not ask a client to provide any supplies. A request for supplies from a client may constitute a violation of Section 8.012, PROVIDERS PROHIBITED FROM COLLECTING PAYMENT FROM RECIPIENTS.
- 2. Supplies other than those required for practice of universal precautions which are used by the Home Health Agency staff to provide Home Health Services are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES.
- 3. Supplies used for the practice of universal precautions by the client's family or other informal caregivers are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES.

8.520.9.D. Restrictions

- 1. When the client has Medicare or other third-party insurance, Home Health claims to Medicaid will be reimbursed only if the client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.
- 2. When an agency provides more than one employee to render a service, in which one employee is supervising or instructing another in that service, the Home Health Agency shall only bill and be reimbursed for one employee's visit or units.
- 3. Any visit made by a nurse or therapist to simultaneously serve two or more clients residing in the same household shall be billed by the Home Health Agency as one visit only, unless services to each client are separate and distinct. If two or more clients residing in the same household receive Medicaid CNA services, the services for each client shall be documented and billed separately for each client.

4. No more than one Home Health Agency may be reimbursed for providing Home Health Services during a specific plan period to the same client, unless the second agency is providing a Home Health Service that is not available from the first agency. The first agency shall take responsibility for the coordination of all Home Health Services. Home and Community Based Services, including personal care, are not Home Health Services.
5. Improper Billing Practices: Examples of improper billing include, but are not limited to:
 - a. Billing for visits without documentation to support the claims billed. Documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.076.2;
 - b. Billing for unnecessary visits, or visits that are unreasonable in number, frequency or duration;
 - c. Billing for CNA visits in which no skilled tasks were performed and documented;
 - d. Billing for skilled tasks that were not medically necessary;
 - e. Billing for Home Health Services provided at locations other than an eligible place of service, except EPSDT services provided with prior authorization; and
 - f. Billing of personal care or homemaker services as Home Health Services.
6. A Home Health Agency that are also certified as a personal care/homemaker provider shall ensure that neither duplicate billing nor unbundling of services occurs in billing for Home Health Services and HCBS personal care services. Examples of duplicate billing and unbundling of services include:
 - a. One employee makes one visit, and the agency bills Medicaid for a CNA visit, and also bills all of the hours as HCBS personal care or homemaker.
 - b. One employee makes one visit, and the agency bills for one CNA visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 1 hour plus the number of hours billed for HCBS personal care and homemaker.
 - c. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of CNA and personal care or homemaker services.
7. The Department may take action against the offending Home Health Agency, including termination from participation in Colorado Medicaid in accordance with 10 C.C.R. 2505-10, Section 8.076.

8.520.10 Compliance Monitoring Reviews

8.520.10.A. General Requirements

1. Compliance monitoring of Home Health Services may be conducted by state and federal agencies, their contractors and law enforcement agencies in accordance with 10 C.C.R. 2505-10, Section 8.076.

2. Home Health Agencies shall submit or produce all requested documentation in accordance with 10 C.C.R. 2505-10, Section 8.076.
3. Physician-signed Plans of Care shall include nursing or therapy assessments, current clinical summaries and updates for the client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485. All sections of the form shall be completed. All therapy services provided shall be included in the Plan of Care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency.
4. Provider records shall document the nature and extent of the care actually provided.
5. Unannounced site visits may be conducted in accordance with C.R.S. Section 25.5-4-301(14)(b).
6. Home Health Services which are duplicative of any other services that the client has received funded by another source or that the client received funds to purchase shall not be reimbursed.
7. Services which total more than twenty-four hours per day of care, regardless of funding source shall not be reimbursed.
8. Billing for visits or contiguous units which are longer than the length of time required to perform all the tasks prescribed on the care plan shall not be reimbursed.
9. Home Health Agencies shall not bill clients or families of client for any services for which Medicaid reimbursement is recovered due to administrative, civil or criminal actions by the state or federal government.

8.520.11 Denial, Termination, or Reduction in Services

- 8.520.11.A. When services are denied, terminated, or reduced by action of the Home Health Agency, the Home Health Agency shall notify the client.
- 8.520.11.B. Termination of services to clients still medically eligible for Coverage of Medicaid Home Health Services:
 1. When a Home Health Agency decides to terminate services to a client who needs and wants continued Home Health Services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the Home Health Agency shall give the client, or the client's designated representative/legal guardian, written advance notice of at least 30 business days. The attending physician and the Department's Home Health Policy Specialist shall also be notified.
 2. Written notice to the client, or client's designated representative/legal guardian shall be provided in person or by certified mail, and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services
 3. The agency shall make a good faith effort to assist the client in securing the services of another agency.

4. If there is indication that ongoing services from another source cannot be arranged by the end of the advance notice period, the terminating agency shall ensure client safety by making referrals to appropriate case management agencies or County Departments of Social Services; and the attending physician shall be informed.
5. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the client, Home Health Agency, staff, or when the client has begun to receive Home Health Services through a Medicaid HMO.

8.535 PEDIATRIC PERSONAL CARE SERVICES

8.535.1 Pediatric Personal Care Services are provided in accordance with the provisions of Appendix A, which sets forth the coverage standards for the benefit.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.1 DEFINITIONS

Family/In-Home Caregiver means an unpaid individual who assumes a portion of the client's Private Duty Nursing care in the home, when Home Health Agency staff is not present. A Family/In-Home Caregiver may either live in the client's home or go to the client's home to provide care.

Home Health Agency means a public agency or private organization or part of such an agency or organization which is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act.

Plan of Care means a care plan developed by the Home Health Agency in consultation with the client, that has been ordered by the attending physician for provision of services to a client at his/her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements at 42 C.F.R. 484.18.

Private Duty Nursing (PDN) means face-to-face Skilled Nursing that is more individualized and continuous than the nursing care that is available under the home health benefit or routinely provided in a hospital or nursing facility.

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

Skilled Nursing means services provided under the licensure, scope and standards of the Colorado Nurse Practice Act, Title 12 Article 38 of the Colorado Revised Statutes, performed by a registered nurse (RN) under the direction of a physician, or a licensed practical nurse (LPN) under the supervision of a RN and the direction of a physician.

Technology Dependent means a client who:

- a. Is dependent at least part of each day on a mechanical ventilator; or
- b. Requires prolonged intravenous administration of nutritional substances or drugs; or
- c. Is dependent daily on other respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support or tube feedings when they are not intermittent.

8.540.2 BENEFITS

8.540.2.A. All PDN services shall be prior authorized by the Department's Utilization Review Contractor (URC).

8.540.2.B. A pediatric client may be approved for up to 24 hours per day of PDN services if the client meets the URC medical necessity criteria. PDN for pediatric clients is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable.

1. The URC shall determine the number of appropriate pediatric PDN hours by considering age, stability, need for frequent suctioning and the ability to manage the tracheostomy.
2. The URC shall consult with the Home Health Agency and the attending physician or primary care physician, to provide medical case management with the goal of resolving the problem that precipitated the need for extended PDN care of more than 16 hours.
3. The URC shall consider combinations of technologies and co-morbidities when making medical criteria determinations.

8.540.2.C. Twenty-four hour care may be approved for pediatric clients during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year.

8.540.2.D. Adult clients may be approved for up to 16 hours of PDN per day.

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

8.540.3 BENEFIT LIMITATIONS

8.540.3.A. A client who meets both the eligibility requirements for PDN and home health shall be allowed to choose whether to receive care under PDN or under home health. The client may choose a combination of the two benefits if the care is not duplicative and the resulting combined care does not exceed the medical needs of the client.

8.540.3.B. Hours of PDN shall never exceed the hours per day that the URC determines are medically necessary.

8.540.4 ELIGIBILITY

8.540.4.A. A client shall be eligible for PDN services when the client is:

1. Technology Dependent.
2. Medically stable, except for acute episodes that can be safely managed under PDN, as determined by the attending physician.
3. Able to be safely served in their home by a home health agency under the agency requirements and limitations of the PDN benefit and with the staff services available.
4. Not residing in a nursing facility or hospital at the time PDN services are delivered.
5. Eligible for Medicaid in a non-institutional setting.

6. Able to meet one of the following medical criteria:
 - a. The client needs PDN services while on a mechanical ventilator.
 - b. The client needs PDN services for ventilator weaning during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions from tracheostomy, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%.
 - c. The pediatric client needs PDN services after tracheostomy decannulation during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions, not using auxiliary muscles for breathing, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%.
 - d. The pediatric client needs PDN services during the hours spent on continuous positive airway pressure (C-PAP), until the client is medically stable.
 - e. The pediatric client needs PDN services for oxygen administration only if there is documentation of rapid desaturation without the oxygen as evidenced by a drop in pulse oximeter readings below 85% within 15-20 minutes, and/or respiratory rate increases, and/or heart rate increases and/or skin color changes. If oxygen is the only technology present, the URC shall review for an individual determination of medical necessity for PDN.
 - f. The pediatric client needs PDN services during the hours required for prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids.
 - g. The URC shall consider combinations of technologies and co-morbidities when making medical determinations for the following medical conditions:
 - i) A pediatric client with tube feedings, including nasogastric tube, gastric tube, gastric button and jejunostomy tube, whether intermittent or not, who is not on mechanical ventilation.
 - ii) An adult client with a tracheostomy, who is not on mechanical ventilation or being weaned from mechanical ventilation.
 - iii) An adult client with a tracheostomy decannulation, who is not on mechanical ventilation or being weaned from mechanical ventilation.
 - iv) An adult client who has Continuous Positive Airway Pressure (C-PAP), but is not on mechanical ventilation or being weaned from mechanical ventilation.
 - v) An adult client with oxygen supplementation, who is not on mechanical ventilation or being weaned from mechanical ventilation.
 - vi) An adult client receiving prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids who is not on mechanical ventilation or being weaned from mechanical ventilation.

- vii) An adult client with tube feedings that are continuous, including nasogastric tube, gastric tube, gastric button and jejunostomy tube who is not on mechanical ventilation nor being weaned from mechanical ventilation.
- 7. The medical judgment of the attending physician and the URC shall be used to determine if the criteria are met wherever the medical criteria are not defined by specific measurements.

8.540.5 APPLICATION PROCEDURES

- 8.540.5.A. The hospital discharge planner shall coordinate with the Home Health Agency to:
 - 1. Refer the client or the client's authorized representative to appropriate agencies for Medicaid eligibility determination in the non-institutional setting, as needed.
 - 2. Plan for the client's hospital discharge by:
 - a. Arrange services with the Home Health Agency, medical equipment suppliers, counselors and other health care service providers as needed.
 - b. Coordinate, in conjunction with the physician and the Home Health Agency, a home care plan that is safe and meets program requirements.
 - c. Advise the Home Health Agency of any changes in medical condition and care needs.
 - d. Ensure that the client, family and caregivers are educated about the client's medical condition and trained to perform the home care.
 - 3. Submit an application to determine PDN eligibility to the URC if the client is hospitalized when services are first requested or ordered.
- 8.540.5.B. The Home Health Agency case coordinator shall submit the application for PDN services to the URC if the client is not in the hospital.
- 8.540.5.C. An application may be submitted up to six months prior to the anticipated need for PDN services. Updated medical information shall be sent to the URC as soon as the service start date is known.
- 8.540.5.D. The application shall be submitted on a Department PDN application form. Any medical information necessary to determine the client's medical need shall be included with the application form.
- 8.540.5.E. If the client has other insurance that has denied PDN coverage, a copy of the denial letter, explanation of benefits or the insurance policy shall be included with the application.
- 8.540.5.F. If services are being requested beyond the 16 hour per day benefit as a result of an EPSDT medical screening, written documentation of those screening results shall be included with the application. The EPSDT claim form shall not meet this requirement.
- 8.540.5.G. The URC nurse reviewer shall review applications for PDN according to the following procedures:
 - 1. Review the information provided and apply the medical criteria.

2. Return the application to the submitting party for more information within seven working days of receipt of an incomplete application if the application is not complete.
 3. Approve the application, or refer the application to the URC physician reviewer within 10 working days of receipt of the complete application. The physician reviewer shall have 10 working days to determine approval or denial of the application for PDN.
 4. Notify the client or the client's designated representative and the submitting party of application approval.
 5. Notify the client, the client's designated representative and the submitting party of the client's appeal rights by placing written notification in the mail within one working day of a denial decision.
- 8.540.5.H. Clients who are approved and who subsequently discontinue PDN for any reason do not need an application to request resumption of PDN services within six months of discontinuing PDN services. Services may be resumed upon approval of a Prior Authorization Request (PAR).

8.540.6 PROVIDER REQUIREMENTS

- 8.540.6.A. A certified Home Health Agency may be authorized to provide PDN services if the agency meets all of the following:
1. Employs nursing staff currently licensed in Colorado with experience in providing PDN or care to Technology-Dependent persons.
 2. Employs nursing personnel with documented skills appropriate for the client's care.
 3. Employs staff with experience or training, in providing services to the client's particular demographic or cultural group.
 4. Coordinates services with a supplemental certified Home Health Agency, if necessary, to meet the staffing needs of the client.
 5. Requires the primary nurse and other personnel to spend time in the hospital prior to the initial hospital discharge or after Re-Hospitalization, to refine skills and learn individualized care requirements.
 6. Provides appropriate nursing skills orientation and on going in-service education to nursing staff to meet the client's specific nursing care needs.
 7. Requires nursing staff to complete cardio pulmonary resuscitation (CPR) instruction and certification at least every two years.
 8. Provides adequate supervision and training for all nursing staff.
 9. Designates a case coordinator who is responsible for the management of home care which includes the following:
 - a. Assists with the hospital discharge planning process by providing input and information to, and by obtaining information from, the hospital discharge planner and attending physician regarding the home care plan.
 - b. Assesses the home prior to the initial hospital discharge and on an ongoing basis for safety compliance.

- c. Submits an application for PDN to the URC if the client is not in the hospital at the time services are requested.
 - d. Refers the client or the client's designated representative to the appropriate agency for Medicaid eligibility determination, if needed.
 - e. Ensures that a completed PAR is submitted to the URC prior to the start of care and before the previous PAR expires.
 - f. Provides overall coordination of home services and service providers.
 - g. Involves the client and Family/In Home Caregiver in the plan for home care and the provision of home care.
 - h. Assists the client to reach maximum independence.
 - i. Communicates changes in the case status with the attending physician and the URC on a timely basis, including changes in medical conditions and/or psychological/social situations that may affect safety and home care needs.
 - j. Assists with communication and coordination between the service providers supplementing the primary Home Health Agency, the primary care physician, specialists and the primary Home Health Agency as needed.
 - k. Makes regular on-site visits to monitor the safety and quality of home care, and makes appropriate referrals to other agencies for care as necessary.
 - l. Ensures that complete and current care plans and nursing charts are in the client's home at all times. Charts shall include interim physician orders, current medication orders and nursing notes. Records of treatments and interventions shall clearly show compliance with the times indicated on the care plans.
 - m. Communicates with Single Entry Point or other case managers as needed regarding service planning and coordination.
- 10. Makes and documents the efforts made to resolve any situation that triggers a discontinuation or refusal to provide services prior to discontinuation or refusal to provide services.
- 11. Documents that the Family/In-Home Caregiver:
 - a. Is able to assume some portion of the client's care.
 - b. Has the specific skills necessary to care for the client.
 - c. Has completed CPR instruction or certification and/or training specific to the client's emergency needs prior to providing PDN services.
 - d. Is able to maintain a home environment that allows for safe home care, including a plan for emergency situations.
 - e. Participates in the planning, implementation and evaluation of PDN services.
 - f. Communicates changes in care needs and any problems to health care providers and physicians as needed.

- g. Works toward the client's maximum independence, including finding and using alternative resources as appropriate.
 - h. Has notified power companies, fire departments and other pertinent agencies, of the presence of a special needs person in the household.
 - 12. Performs an in-home assessment and documents that the home meets the following safety requirements:
 - a. Adequate electrical power including a back up power system.
 - b. Adequate space for equipment and supplies.
 - c. Adequate fire safety and adequate exits for medical and other emergencies.
 - d. A clean environment to the extent that the client's life or health is not at risk.
 - e. A working telephone available 24 hours a day.
- 8.540.6.B. The Home Health Agency shall coordinate with the client's attending physician to:
 - 1. Determine that the client is medically stable, except for acute episodes that can be managed under PDN, and that the client can be safely served under the requirements and limitations of the PDN benefit.
 - 2. Cooperate with the URC in establishing medical eligibility.
 - 3. Prescribe a plan of care at least every 60 days.
 - 4. Coordinate with any other physicians who are treating the client.
 - 5. Communicate with the Home Health Agency about changes in the client's medical condition and care, especially upon discharge from the hospital.
 - 6. Empower the client and the Family/In-Home Caregiver by working with them and the Home Health Agency to maximize the client's independence.
- 8.540.7 PRIOR AUTHORIZATION PROCEDURES**
- 8.540.7.A. The Home Health Agency shall submit the initial PAR to the URC prior to the start of PDN.
- 8.540.7.B. The PAR shall be approved for up to six months for a new client and up to one year for ongoing care depending upon prognosis for improvement or recovery, according to the medical criteria.
- 8.540.7.C. The PAR information shall:
 - 1. Be submitted on a Department PAR form. A copy of the current plan of care shall be included. For new clients admitted to PDN directly from the hospital, a copy of the transcribed verbal physician orders may be substituted for the plan of care if the client has been approved for admission to PDN.
 - 2. Be submitted with the plan of care that:

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- a. Is on the CMS 485 form, or a form that is identical in format to the CMS 485. All sections of the form relating to nursing needs shall be completed.
 - b. Includes a signed nursing assessment, a current clinical summary or update of the client's condition and a physician's plan of treatment. A hospital discharge summary shall be included if there was a hospitalization since the last PAR.
 - c. Indicates the frequency and the number of times per day that all technology-related care is to be administered. Ranges and a typical number of hours needed per day are required. The top of the range is the number of hours ordered by the physician as medically necessary. The lower number is the amount of care that may occur due to family availability or choice, holidays or vacations or absence from the home.
 - d. Includes a process by which the client receiving services and support may continue to receive necessary care, which may include respite care, if the client's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or the caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.
 3. Include an explanation for the decision to use an LPN. This decision shall be at the discretion of the attending physician, the Home Health Agency and the RN responsible for supervising the LPN.
 4. Cover a period of up to one year depending upon medical necessity determination.
 5. Include only the services of PDN-RN and/or PDN-LPN. If any other services are included on the PAR, the URC shall return the PAR without processing it.
 6. Be submitted within five working days of the change as a revision when a change in the plan of care results in an increase in hours. A revised plan of care or a copy of the physician's verbal orders for the increased hours including the effective date shall be included with the PAR form.
 7. Be submitted to decrease the number of hours for which the client may be eligible when a change in the client's condition occurs which could affect the client's eligibility for PDN, or decrease the number of hours for which the client may be eligible. The agency shall notify the URC within one working day of the change. Failure to notify the URC may result in recovery of inappropriate payments, if any, from the Home Health Agency.
 8. Be submitted within five working days of the discharge or death, as a revised PAR when a client is discharged or dies prior to the end date of the PAR. The revision is to the end date and the number of service units.
- 8.540.7.D. The URC shall review PARs according to the following procedures:
1. Review information provided and apply the medical criteria as described herein.
 2. Return an incomplete PAR to the Home Health Agency for correction within seven working days of receipt.
 3. Approve the PAR, or refer the PAR to the URC physician reviewer, within 10 working days of receipt of the complete PAR.
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4. Process physician review referrals and approve, partially approve, or deny the PAR within 10 working days of receipt from the nurse reviewer. The URC physician reviewer shall attempt to contact the attending physician or the primary care physician for more information prior to a denial or reduction in services.
 5. Provide written notification to the client or client's designated representative and submitting party of all PAR denials and the client's appeal rights, within one working day of the decision.
 6. Approve subsequent continued stay PARs that have been to physician review without referral, if the client's condition and the requested hours have not changed.
 7. Notify the Department of all extraordinary PDN services approved as a result of an EPSDT screen.
 8. Notify the submitting party of all PAR approvals.
 9. Expedite PAR reviews in situations where adhering to the time frames above would seriously jeopardize the client's life or health.
- 8.540.7.E. No services shall be approved for dates of service prior to the date the URC receives a complete PAR. PAR revisions for medically necessary increased services may be approved back to the day prior to receipt by the URC if the revised PAR was received within five working days of the increase in services. Facsimiles may be accepted.
- 8.540.7.F. The URC nurse reviewer may attend hospital discharge planning conferences, and may conduct on site visits to each client at admission and every six months thereafter.

8.540.8 REIMBURSEMENT

- 8.540.8.A. No services shall be authorized or reimbursed if hours of service, regardless of funding source, total more than 24 hours per day.
- 8.540.8.B. No services shall be reimbursed if the care is duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health or other insurance.
- 8.540.8.C. Approval of the PAR by the URC shall authorize the Home Health Agency to submit claims to the Medicaid fiscal agent for authorized PDN services provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the provider's use of correct billing procedures.
- 8.540.8.D. No services shall be reimbursed for dates of service prior to the PAR start date as authorized by the URC.
- 8.540.8.E. Skilled Nursing services under the PDN shall be reimbursed in units of one hour, at the provider's usual and customary charge or the maximum Medicaid allowable rates established by the Department, whichever is less. Units of one hour may be billed for RN, LPN, RN group rate (registered nurse providing PDN to more than one client at the same time in the same setting), LPN group rate (licensed practical nurse providing PDN to more than one client at the same time in the same setting) or Blended RN/LPN rate (group rate by request of the Home Health Agency only).

8.550 HOSPICE BENEFIT

8.550.1 DEFINITIONS

Alternative Care Facility (ACF) means an assisted living residence that is enrolled as a Medicaid provider.

Assisted Living Residence means an assisted living residence as defined in 6 CCR 1011-1 Chapter VII.

Benefit Period means a period during which the client has made an Election to receive hospice care defined as one or more of the following:

1. An initial 90-day period.
2. A subsequent 90-day period.
3. An unlimited number of subsequent 60-day periods.

The periods of care are available in the order listed and may be Elected separately at different times.

Certification means that the client's attending physician and/or the Hospice Provider's medical director have affirmed that the client is Terminally Ill.

Client Record means a medical file containing the client's Election of Hospice, eligibility documentation, and other medical records.

Department means the Colorado Department of Health Care Policy and Financing. The Department is designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

Election/Elect means the client's written expression to choose Hospice care for Palliative and Supportive Medical Services. Home Care Services means Hospice Services that are provided primarily in the client's home but may be provided in a residential facility and/or licensed or certified health care facility.

Hospice means a centrally administered program of palliative, supportive, and Interdisciplinary Team services providing physical, psychological, sociological, and spiritual care to Terminally Ill clients and their families.

Hospice Provider means a Medicaid and Medicare-certified Hospice provider.

Hospice Services means counseling, certified nurse aide, personal care worker, homemaker, nursing, physician, social services, physical therapy, occupational therapy, speech therapy, and trained volunteer services.

Interdisciplinary Team means a group of qualified individuals, consisting of at least a physician, registered nurse, clergy, counselors, volunteer director or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice clients and their families.

Intermediate Care Facility for People with Intellectual Disabilities means a care facility which is designed, and functions, to meet the needs of four or more individuals with developmental disabilities, or related conditions, who require twenty-four hour active treatment services.

Medical Necessity or Medically Necessary is defined in Section 8.076.1.8.

Palliative and Supportive Medical Services means those services and/or interventions which are not curative but which produce the greatest degree of relief from the symptoms of the Terminal Illness.

Room and Board includes a place to live and the amenities that come with that place to live, including but not limited to provision of:

1. Meals and additional nutritional requirements, as prescribed;
2. Performance of personal care services, including assistance with activities of daily living;
3. Provision of social activities;
4. Equipment necessary to safely care for the client and to transport the client, as necessary;
5. Administration of medication;
6. Maintenance of the cleanliness of a client's room; and
7. Supervision and assistance in the use of durable medical equipment and prescribed therapies.

Terminally Ill/Terminal Illness means a medical prognosis of life expectancy of nine months or less, should the illness run its normal course.

8.550.2 INITIATION OF HOSPICE

8.550.2.A. Certification

The Hospice Provider must obtain Certification that a client is Terminally Ill in accordance with the following procedures:

1. For the first Benefit Period of Hospice coverage or re-Election following revocation or discharge from the Hospice benefit, the Hospice Provider must obtain:
 - a. A written Certification signed by either the Hospice Provider's medical director or the physician member of the Interdisciplinary Team and the client's attending physician. The written Certification must be obtained and placed in the Client Record within two calendar days after Hospice Services are initiated. The written Certification must include:
 - i) A statement of the client's life expectancy including diagnosis of the terminal condition, other health conditions whether related or unrelated to the terminal condition, and current clinically relevant information supporting the diagnoses and prognosis for life expectancy and Terminal Illness;
 - ii) The approval of the client's physician(s) for Hospice Services; and
 - iii) The approval of the Hospice Provider of Hospice Services for the client.
 - b. A verbal Certification statement from either Hospice Provider's medical director or the physician member of the Interdisciplinary Team and the client's attending physician, if written certification cannot be obtained within two calendar days after Hospice Services are initiated. The verbal Certification must be documented, filed in the Client Record, and include the information described at Section 8.550.2.A.1.a.i, ii, and iii. Written Certification documentation must follow and be filed in the Client Record prior to submitting a claim for payment.

2. At the beginning of each subsequent Benefit Period, the Hospice Provider must obtain a written re-Certification prepared by either the attending physician, the Hospice Provider's medical director or the physician member of the Interdisciplinary Team.

8.550.2.B. Election Procedures

1. An Election of Hospice Services continues as long as there is no break in care and the client remains with the Elected Hospice Provider.
2. If a client Elects to receive Hospice Services, the client or client representative must file an Election statement with the Hospice Provider that must be maintained in the Client's Record and must include:
 - a. Designation of the Hospice Provider. A client must choose only one Hospice Provider as the designated Hospice Provider;
 - b. Acknowledgment that the client or client representative has a full understanding of the palliative rather than curative nature of Hospice Services;
 - c. Designation by the client or client representative of the effective date for the Election period. The first day of Hospice Services must be the same or a later date;
 - d. An acknowledgement that for the duration of the Hospice Services, the client waives all rights to Medicaid payments for the following services:
 - i) Hospice Services provided by a Hospice Provider other than the provider designated by the client (unless provided under arrangements made by the designated Hospice Provider);
 - ii) Any Medicaid services that are related to the treatment of the terminal condition for which Hospice Services were Elected, or a related condition, or that are equivalent to Hospice Services, except for services that are:
 - 1) Provided by the designated Hospice Provider;
 - 2) Provided by another Hospice Provider under arrangements made by the designated Hospice Provider;
 - 3) Provided by the individual's attending physician if that physician is not an employee of the designated Hospice Provider or receiving compensation from the Hospice Provider for those services; and,
 - 4) Services provided to clients ages 20 and under.
 - e. A signature of either the client or client representative as allowed by Colorado law.
3. A client or client representative may revoke the Election of Hospice Services by filing a signed statement of revocation with the Hospice Provider. The statement must include the effective date of the revocation. The client must not designate an effective date earlier than the date that the revocation is made. Revocation of the Election of Hospice Services ends the current Hospice Benefit Period.

- a. Clients who are dually eligible for Medicare and Medicaid must revoke the Election of Hospice Services under both programs.
4. The client may resume coverage of the waived benefits as described at 8.550.2.B.2.d. upon revoking the Election of Hospice Services.
5. The client may re-Elect to receive Hospice Services at any time after the services are discontinued due to discharge, revocation, or loss of Medicaid eligibility, should the client thereafter become eligible.
6. The client may change the designation of the Hospice Provider once each Benefit Period. A change in designation of Hospice Provider is not a revocation of the client's Hospice Election. To change the designation of the Hospice Provider, the client must file a statement with the current and new provider which includes:
 - a. The name of the Hospice Provider from which the client is receiving care and the name of the Hospice Provider from which he or she plans to receive care;
 - b. The date the change is to be effective; and
 - c. The signature of the client or client representative.

8.550.3 HOSPICE RELATED TO HCBS WAIVERS

8.550.3.A. Provision of Services

1. Hospice Services may be provided to a client who is enrolled in one of the Colorado Medicaid home and community-based services (HCBS) waivers, including the children with life limiting illness waiver.
2. HCBS waiver services may be provided for conditions unrelated to the client's terminal diagnosis. For children ages 20 and under, HCBS waivers services may be provided for conditions related or unrelated to the client's terminal diagnosis.
3. HCBS waiver services may also be provided to the client when these services are not duplicative of the services that are the responsibility of the Hospice Provider. HCBS waivers are those waivers as defined at Sections 8.500 through 8.599.

8.550.3.B. Waiver Coordination

1. The Hospice Provider must notify the HCBS waiver case manager or support coordinator of the client's Election of Hospice Services and the anticipated start date.
2. The Hospice Provider must coordinate Hospice Services and HCBS waiver services with the HCBS waiver case manager or support coordinator and must document coordination of these services in the Client Record. Documentation must include:
 - a. Identification of the Hospice Services that will be provided;
 - b. Identification of the HCBS waiver services that will be provided under the waiver; and
 - c. Integration of Hospice Services and HCBS waiver services in the Hospice plan of care.

3. The Hospice Provider must invite the HCBS waiver case manager or support coordinator to participate in the Interdisciplinary Team meetings for the client when possible.

8.550.4 BENEFITS

8.550.4.A. Hospice Standard of Care

1. Hospice Services must be reasonable and Medically Necessary for the palliation or management of the Terminal Illness as well as any related condition, but not for the prolongation of life.
2. Clients ages 20 and under are exempt from the restriction on care for the prolongation of life.

8.550.4.B. Covered Services

Covered Hospice Services include, but are not limited to:

1. Nursing care provided by or under the supervision of a registered nurse.
2. Medical social services provided by a qualified social worker or counselor under the direction of a physician.
3. Counseling services, including dietary and spiritual counseling, provided to the Terminally Ill client and his or her family members or other persons caring for the client.
4. Bereavement counseling delivered through an organized program under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the client).
5. Short-term general inpatient care necessary for pain control and/or symptom management up to 20 percent of total Hospice Service days.
6. Short-term inpatient care of up to five consecutive days per Benefit Period to provide respite for the client's family or other home caregiver.
7. Medical appliances and supplies, including pharmaceuticals and biologicals which are used primarily for symptom control and relief of pain related to the Terminal Illness.
8. Intermittent certified nurse aide services available and adequate in frequency to meet the needs of the client. Certified nurse aides practice under the general supervision of a registered nurse. Certified nurse aide services may include unskilled personal care and homemaker services that are directly related to a visit.
9. Occupational therapy, physical therapy, and speech-language pathology appropriate to the terminal condition, provided for the purposes of symptom control or to enable the terminal client to maintain activities of daily living and basic functional skills.
10. Trained volunteer services.
11. Any other service that is specified in the client's plan of care as reasonable and Medically Necessary for the palliation and management of the client's Terminal Illness and related conditions and for which payment may otherwise be made under Medicaid.

8.550.4.C. [Expired 05/15/2014 per House Bill 14-1123]

8.550.4.D. Non-Covered Services

Services not covered as part of the Hospice Benefit include, but are not limited to:

1. Services provided before or after the Hospice Election period.
2. Services of the client's attending or consulting physician that are unrelated to the terminal condition which are not waived under the Hospice Benefit.
3. Services or medications received for the treatment of an illness or injury not related to the client's terminal condition.
4. Services which are not otherwise included in the Hospice benefit, such as electronic monitoring, non-medical transportation, and home modification under a Home and Community-Based Services (HCBS) program.
5. Personal care and homemaker services beyond the scope provided under Hospice Services which are contiguous with a certified nurse aide visit.
6. Hospice Services covered by other health insurance, such as Medicare or private insurance.
7. Hospice Services provided by family members.

8.550.4.E. Prior Authorization

Prior authorization is not required for Hospice Services.

8.550.4.F. Intermittent Home Health Certified Nurse Aide Services

Intermittent home health certified nurse aide services may be utilized with Hospice Services coordination for treatment of conditions that are not related to the terminal diagnosis and are not meant to cure the client's terminal condition. Children under 20 are exempt from this requirement.

8.550.4.G. Included Activities

Medicaid does not separately reimburse for activities that are the responsibility of the Hospice Provider, including coordination of care for the client and bereavement counseling.

8.550.5 ELIGIBLE PLACE OF SERVICE

8.550.5.A. Place of Service

1. Hospice Services are provided in a client's place of residence, which includes:
 - a. A residence such as, but not limited to, a house, apartment or other living space that the client resides within;
 - b. An assisted living residence including an Alternative Care Facility;

- c. A temporary place of residence such as, but not limited to, a relative's home or a hotel. Temporary accommodations may include homeless shelters or other locations provided for a client who has no permanent residence to receive Hospice Services;
 - d. Other residential settings such as a group home or foster home;
 - e. A licensed Hospice Facility or Nursing Facility (NF);
 - f. An Intermediate Care Facility for the Intellectually Disabled (ICF/ID), or Nursing Facility (NF), unless the client is in a waiver program which does not allow residency in an ICF/ID or NF; or
 - g. An Individual Residential Services & Supports (IRSS) or a Group Residential Services & Supports (GRSS) host home setting.
- 2. For Hospice clients residing in a NF, ICF/ID, IRSS or GRSS, the client must meet both the Hospice requirements and the requirements for receipt of those Medicaid-covered services.
 - 3. Colorado Medicaid does not reimburse Hospice Services provided in hospitals except when the client has been admitted for respite services.

8.550.5.B. Hospice Setting Requirements

- 1. Nursing Facilities:
 - a. Hospice Services may be provided to a client who resides in a Medicaid participating NF.
 - b. When a client residing in a NF Elects Hospice Services, the client is considered a Hospice client and is no longer a NF client with the exception of the facility's responsibility to provide Room and Board to the client.
 - c. In order for a client to receive Hospice Services while residing in a NF, the Hospice Provider must:
 - i) Notify the NF that the client has Elected Hospice and the expected date that Hospice Services will commence;
 - ii) Ensure the NF concurs with the Hospice plan of care;
 - iii) Ensure the NF is Medicaid certified; and
 - iv) Execute a written agreement with the NF, which must include the following:
 - 1) The means through which the NF and the Hospice Provider will communicate with each other and document these communications to ensure that the needs of clients are addressed and met 24 hours a day;
 - 2) An agreement on the client's Hospice Service plan of care by the NF staff;

- 3) A means through which changes in client status are reported to the Hospice Provider and NF;
 - 4) A provision stating that the Hospice Provider is considered the primary provider and is responsible for any Medically Necessary routine care or continuous care related to the Terminal Illness and related conditions;
 - 5) A provision stating that the Hospice Provider assumes responsibility for determining the appropriate course of Hospice Services, including the determination to change the level of services provided;
 - 6) An agreement that it is the NF provider's responsibility to continue to furnish 24 hour Room and Board care, meeting the personal care, durable medical equipment and nursing needs that would have been provided by the NF at the same level of care provided prior to Hospice Services being Elected;
 - 7) An agreement that it is the Hospice Provider's responsibility to provide services at the same level and to the same extent that those services would be provided if the client were residing in his or her own residence;
 - 8) A provision that the Hospice Provider may use NF personnel, where permitted by State law and as specified by the agreement, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice Provider would routinely use the services of a client's family in implementing the plan of care;
 - 9) The NF remains responsible for compliance with mandatory reporting of such violations to the State's protective services agency. As such, the Hospice Provider and its staff or subcontractors must report all alleged violations of a client's person involving mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of client property to the NF administrator within 24 hours of the Hospice Provider becoming aware of the alleged violation;
 - 10) Bereavement services that the Hospice Provider will provide to the NF staff;
 - 11) The amount to be paid to the NF or ICF/ID by the Hospice Provider; and
 - 12) An agreement describing whether the Hospice Provider or the NF will be responsible for collecting the client's patient payment for his or her care.
2. Intermediate Care Facilities, Independent Residential Support Services, and Group Residential Support Services settings:

- a. Hospice Services may be provided to a client who resides in a Medicaid participating ICF/ID, IRSS or GRSS residential settings. When a client resides in one of the settings, the client remains a resident of the ICF/ID, IRSS or GRSS residence. The Hospice Provider must provide services as if treating a client in his or her place of residence.
- b. The Hospice Provider is not responsible for reimbursing the IRSS or GRSS for the client's Room and Board.
- c. In order for a client to receive Hospice Services while residing in these settings, the Hospice Provider must work with the ICF/ID, IRSS or GRSS to:
 - i) Notify the ICF/ID, IRSS or GRSS that the client has Elected Hospice and the expected date that Hospice Services will commence;
 - ii) Ensure the ICF/ID, IRSS or GRSS concurs with the Hospice plan of care;
 - iii) Determine the responsibilities covered under the ICF/ID, IRSS or GRSS so that the Hospice Provider does not duplicate service (to include medication and supplies), including:
 - 1) An agreement that the Hospice Provider will be responsible to provide services at the same level and to the same extent as those services would be provided if the client were residing in his or her private residence; and
 - 2) An agreement of the services the ICF/ID, IRSS or GRSS personnel will perform, where permitted by State law, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice Provider would routinely use the services of a client's family in implementing the plan of care;
 - iv) Develop a coordinated plan of care to ensure that the client's needs are met;
 - v) Develop a communication plan through which the Hospice Provider and the ICF/ID, IRSS or GRSS will communicate changes in the client's condition or changes in the client's care plan to ensure that the client's needs are met; and
 - vi) Ensure bereavement services are available to the staff and caregivers of the client.
- 3. In settings other than nursing facilities and ICF/IDs, the Hospice Provider and assisted living residence or foster home must develop an agreement related to the provision of care to the client, including:
 - a. Hospice Provider staff access to and communication with staff or caregivers in these facilities or homes;
 - b. Developing an integrated plan of care;
 - c. Documenting both respective entities' records, or other means to ensure continuity of communication and easy access to ongoing information;

- d. Role of any Hospice vendor in delivering and administering any supplies and medications;
- e. Ordering, renewing, delivering and administering medications;
- f. Role of the attending physician and process for obtaining and implementing orders;
- g. Communicating client change of condition; and
- h. Changes in the client's needs that necessitate a change in setting or level of care.

8.550.6 ELIGIBLE CLIENTS

8.550.6.A. Requirements

To be eligible to Elect Hospice Services, all of the following requirements must be met:

- 1. Clients must be Medicaid eligible on the dates of service for which Medicaid-covered Hospice Services are billed. The services must be Medically Necessary, including certification of the client's Terminal Illness, and appropriate to the client's needs in order for Hospice Services to be covered by Medicaid.
- 2. The client has been certified as being Terminally Ill by an attending physician or the Hospice Provider's medical director.
- 3. Before services are provided, an initial plan of care must be established by the Hospice Provider in collaboration with the client and anyone else that the client wishes to have present for care planning. When the client is unable to direct his or her own care, care planning must involve the client's family or caregiver.
- 4. The client has agreed to cease any and all curative treatment. Clients ages 20 and younger are exempt from this requirement.
- 5. Hospice clients residing in an ICF/ID or NF must meet the Hospice eligibility criteria pursuant to Section 8.550 et. seq., together with functional eligibility, medical eligibility criteria, and the financial eligibility criteria for institutional care as required by Sections 8.400, 8.401, and 8.482.
- 6. Clients who do not meet eligibility requirements for State Plan Medicaid may be eligible for Medicaid through the long-term care eligibility criteria, which may require the client to pass a level of care assessment through a designated case management agency.

8.550.6.B. Special Requirements

- 1. Eligibility for, and access to, Hospice Services does not fall within the purview of the long term care Single Entry Point system for prior authorization.
- 2. Nursing facility placement for a client who has Medicaid and has Elected Hospice Services in a nursing facility does not require a long term care ULTC 100.2 assessment. The nursing facility must complete a Pre Admission Screening and Resident Review (PASRR).

8.550.7 DISCHARGE

8.550.7.A. A Hospice Provider may discharge a client when:

1. The client moves out of the Hospice Provider's service area or transfers to another Hospice Provider;
2. The Hospice Provider determines that the client is no longer Terminally Ill; or
3. The Hospice Provider determines, under a policy set by the Hospice Provider for the purpose of addressing discharge for cause that meets the requirements of 42 C.F.R. Section 418.26(a)(3) (2018), that the client's (or other person in the client's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care or the Hospice Provider's ability to operate effectively is seriously impaired. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.
 - a. The Hospice Provider must:
 - i) Advise the client that a discharge for cause is being considered;
 - ii) Make a serious effort to resolve the problem presented by the situation;
 - iii) Ascertain that the proposed discharge is not due to the client's use of necessary Hospice Services;
 - iv) Document the problem and the effort made to resolve the problem; and
 - v) Enter this documentation into the client's medical record.
4. The Hospice Provider must obtain a written discharge order from the Hospice Provider's medical director prior to discharging a client for any of the reasons in this section.
5. The Hospice Provider medical director must document that the attending physician involved in the client's care has been consulted about the discharge and include the attending physician's review and decision in the discharge note.
6. The Hospice Provider must have in place a discharge planning process that takes into account the prospect that a client's condition might stabilize or otherwise change such that the client cannot continue to be certified as Terminally Ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the client is discharged because he or she is no longer Terminally Ill.
7. The Hospice Provider must implement the discharge planning process to ensure to the maximum extent feasible, that the client's needs for health care and related services upon termination of Hospice Services will be met.
8. The Hospice Provider must document whether the client or client's authorized representative was involved in the discharge planning.
9. The Hospice Provider must document the transition plan for the client.

8.550.8 PROVIDER REQUIREMENTS

8.550.8.A. Licensure

The Hospice Provider must be licensed by the Colorado Department of Public Health and Environment, have a valid provider agreement with the Department and be Medicare certified as being in compliance with the conditions of participation for a Hospice Provider as set forth at 42 C.F.R. §§ 418.52 through 418.116 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

8.550.8.B. Qualified Personnel

Hospice Services must be performed by appropriately qualified personnel:

1. Physicians who are a doctor of medicine or osteopathy licensed in accordance with the Colorado Medical Practice Act (C.R.S. § 12-36-101, et seq.);
2. Advanced Practice Nurses and Physician Assistants licensed in accordance with the Colorado Nurse Practice Act and the Colorado Medical Practice Act;
3. Registered Nurses (RN) and Licensed Practical Nurses (LPN), licensed in accordance with the Colorado Nurse Practice Act (C.R.S. § 12-38-101, et seq.);
4. Physical therapists who are licensed in accordance with the Colorado Physical Therapy Practice Act (C.R.S. § 12-41-101 et seq.);
5. Occupational therapists who are licensed in accordance with the Colorado Occupational Therapy Practice Act (C.R.S. § 12-40.5-101, et seq.);
6. Speech language pathologists who are certified by the American Speech-Language-Hearing Association (ASHA);
7. Licensed clinical social workers who have a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education, or a baccalaureate degree in psychology, sociology, or other field related to social work and who are supervised by a social worker with a Master's Degree in Social Work and who have one year of social work experience in a health care setting;
8. Certified nurse aides who are certified in accordance with the Colorado Nurse Aide Practice Act (C.R.S. § 12-38-101, et seq.) and who have appropriate training. At the option of the Hospice Provider, homemakers with appropriate training may provide homemaking services, which is included as a component of Hospice Services;
9. Hospice volunteers who have received volunteer orientation and training that is consistent with Hospice industry standards;
10. Members of the clergy or religious support services; and
11. Members of the Hospice Interdisciplinary Team acting within the scope of his or her license, as determined by the Hospice Provider.

8.550.8.C. Laboratory Services

1. Laboratory services provided by Hospice Providers are subject to the requirements of 42 U.S.C. § 263a (2012) entitled the Clinical Laboratory Improvement Act of 1967 (CLIA). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.
2. Hospice Providers must obtain a CLIA waiver from the Department of Public Health and Environment to perform laboratory tests. A Hospice Provider that collects specimens, including drawing blood, but does not perform testing of specimens is not subject to CLIA requirements.

8.550.8.D. Provider Responsibilities

1. A Hospice Provider must routinely provide all core services by staff employed by the Hospice Provider. These services must be provided in a manner consistent with acceptable standards of practice. Core services include nursing services, certified nursing aide services, medical social services, and counseling.
2. The Hospice Provider may contract for physician services. The contracted provider(s) will function under the direction of the Hospice Provider's medical director.
3. A Hospice Provider may use contracted staff, if necessary, to supplement Hospice Provider employees in order to meet the needs of the client. A Hospice Provider may also enter into a written arrangement with another Colorado Medicaid and Medicare certified Hospice program for the provision of core services to supplement Hospice Provider employees/staff to meet the needs of clients. Circumstances under which a Hospice Provider may enter into a written arrangement for the provision of core services include:
 - a. Unanticipated periods of high client loads, staffing shortages due to illness or other short-term, temporary situations that interrupt client care;
 - b. Temporary travel of a client outside of the Hospice Provider's service area; and
 - c. When a client resides in a NF, ICF/ID, IRSS or GRSS.
4. The Hospice Provider must ensure, prior to the provision of Medicaid Hospice Services, that clients are evaluated to determine whether or not they are Medicare eligible. Hospice Services are not covered by Medicaid during the period when a client is Medicare eligible, except for clients residing in a NF in which case Medicaid pays to the Hospice Provider an amount for Room and Board.
5. The Hospice Provider must ensure a client, or his or her legally authorized representative, completes the Hospice Election form prior to or at the time Medicaid Hospice Services are provided.

6. Medicare Hospice Election may not occur retroactively. Therefore, clients with retroactive Medicare eligibility may receive Medicaid covered services during the retroactive coverage period. The Hospice Provider must make reasonable efforts to determine a client's status concerning Medicare eligibility or a client's application for Medicare and must maintain documentation of these efforts. These efforts must include routine and regular inquiry to determine Medicare eligibility for clients who reach the age of sixty-five and regular inquiry for clients who indicate they receive Supplemental Security Disability Income (SSDI) and are approaching the 24th month of receipt of SSDI. See also Section 8.550.3.
7. Clients who are eligible for Medicare and Medicaid must Elect Hospice Services under both programs.
8. If a client becomes eligible for Medicaid while receiving Medicare Hospice benefits, Medicare Hospice coverage continues under its current Election period and Medicaid Hospice coverage begins at Medicaid's first Election period.
9. An individual Client Record must be maintained by the designated Hospice Provider and must include:
 - a. Documentation of the client's eligibility for and Election of Hospice Services including the physician certification and recertification of Terminal Illness;
 - b. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes;
 - c. The amount, frequency, and duration of services delivered to the client based on the client's plan of care;
 - d. Documentation to support the care level for which the Hospice Provider has claimed reimbursement; and
 - e. Medicaid provider orders.
10. Incomplete documentation in the Client Record shall be a basis for recovery of overpayment.
11. Notice of the client's Election and Benefit Periods must be provided to the Medicaid fiscal agent in such form and manner as prescribed by the Department.
12. The Hospice Provider must provide reports and keep records as the Department determines necessary including records that document the cost of providing care.
13. The Hospice Provider must perform case management for the client. Medicaid will not reimburse the Hospice Provider separately for this responsibility.
14. The Hospice Provider must designate an Interdisciplinary Team composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the clients and his or her family facing Terminal Illness and bereavement. Interdisciplinary Team members must provide the care and services offered by the Hospice Provider. The Interdisciplinary Team, in its entirety, must supervise the care and services.
15. The Interdisciplinary Team includes, but is not limited to:

- a. A doctor of medicine or osteopathy, advanced practice nurse, or physician assistant (who is an employee or under contract with the Hospice Provider);
 - b. A registered nurse or licensed practical nurse;
 - c. A social worker;
 - d. A pastoral or other counselor; and
 - e. The volunteer coordinator or designee.
16. The Hospice Provider must designate a member of the Interdisciplinary Team to provide coordination of care and to ensure continuous assessment of each client's and family's needs and implementation of the interdisciplinary plan of care. The designated member must oversee coordination of care with other medical providers and agencies providing care to the client.
17. All Hospice Services and services furnished to clients and their families must follow an individualized written plan of care established by the Hospice Interdisciplinary Team in collaboration with the client's primary provider (if any), the client or his or her representative, and the primary caregiver in accordance with the client's needs and desires.
18. The plan of care must be established prior to providing Hospice Services and must be based on a medical evaluation and the written assessment of the client's needs and the needs of the client's primary caregiver(s).
19. The plan of care must be maintained in the client's record and must specify:
- a. The client's medical diagnosis and prognosis;
 - b. The medical and health related needs of the client;
 - c. The specific services to be provided to the client through Hospice and when necessary the NF, ICF/ID, IRSS or GRSS;
 - d. The amount, frequency and duration of these services; and
 - e. The plan of care review date.
20. The plan of care must be reviewed as needed, but no less frequently than every 15 days. The Interdisciplinary Team leader must document each review. The Interdisciplinary Team members, including the Medicaid provider who is managing the client's care, must sign the plan of care.
21. The Hospice Provider must ensure that each client and his or her primary care giver(s) receive education and training provided by the Hospice Provider as appropriate based on the client's and primary care giver(s)' responsibilities for the care and services identified in the plan of care.
22. The Hospice Provider is responsible for paying for medications, durable medical equipment, and medical supplies needed for the palliation and management of the client's Terminal Illness.

8.550.9 REIMBURSEMENT

8.550.9.A. Reimbursement Determination

Reimbursement follows the method prescribed in 42 C.F.R. §§ 418.301 through 418.309 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.

1. Reimbursement rates are determined by the following:
 - a. Rates are published by the Department annually in compliance with the Centers for Medicare and Medicaid Services (CMS) state Medicaid Hospice reimbursement.
 - b. Each care-level per-diem rate is subject to a wage index multiplier, to compensate for regional differences in wage costs, plus a fixed non-wage component.
 - c. The Hospice wage indices are published annually by October 1 in the Federal Register.
 - d. Rates are adjusted for cost-of-living increases and other factors as published by the Centers for Medicare and Medicaid Services.
 - e. Continuous home care is reimbursed at the applicable hourly rate, the per-diem rate divided by 24 hours, multiplied by the number of hourly units billed from eight up to 24 hours per day of continuous care (from midnight to midnight).
 - f. Reimbursement for routine home care and continuous home care must be based upon the geographic location at which the service is furnished and not on the business address of the Hospice Provider.
2. Reimbursement for Hospice Services must be made at one of four predetermined care level rates, including the routine home care rate, continuous home care rate, inpatient respite care rate, and general inpatient care rate. If no other level of care is indicated on a given day, it is presumed that routine home care is the applicable rate.
 - a. Care levels and reimbursement guidelines:
 - i) The routine home care rate is reimbursed for each day the client is at home and not receiving continuous home care. This rate is paid without regard to the volume or intensity of Home Care Services provided. This is the service type that must be utilized when a client resides in a NF, ICF/ID, IRSS or GRSS unless the client is in a period of crisis.

- ii) The continuous home care rate is reimbursed when continuous home care is provided and only during a period of medical crisis to maintain a client at home. A period of crisis is a period in which a client requires continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Either a registered nurse or a licensed practical nurse must provide more than half of the billed continuous homecare hours. Homemaker and certified nurse aide services may also be provided to supplement nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate shall be reimbursed up to 24 hours a day. Continuous home care must not be utilized when a client resides in a NF, ICF/ID, IRSS or GRSS unless the client is in a period of crisis.
 - iii) The inpatient respite care rate is paid for each day on which the client is in an approved inpatient facility for respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. Payment for inpatient respite care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9.B.
 - iv) The general inpatient rate must be paid only during a period of medical crisis in which a client requires 24 hour continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Payment for general inpatient care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9.B.
- 3. The Hospice Provider is paid a Room and Board fee in addition to the Hospice per diem for each routine home care day and continuous care day provided to clients residing in an ICF/ID or NF.
 - a. The payment for Room and Board is billed by and reimbursed to the Hospice provider on behalf of the client residing in the facility. The Department reimburses 95 percent of the facility per diem amount less any patient payments.
 - b. Payments for Room and Board are exempt from the computation of the Hospice payment cap.
 - c. The Hospice Provider must forward the Room and Board payment to the NF or ICF/ID.
 - d. Clients who are eligible for Post Eligibility Treatment of Income (PETI) shall be eligible for PETI payments while receiving services from a Hospice Provider. The Hospice Provider must submit claims on behalf of the client and nursing facility or ICF/ID.
 - e. Patient payments for Room and Board charges must be collected for Hospice clients residing in a NF or ICF/ID as required by Section 8.482. While the Medicaid NF and ICF/ID Room and Board payments must be made directly to the Hospice Provider, the patient payment must be collected by the nursing facility or ICF/ID.

- f. Nursing facilities, ICF/IDs, and Hospice Providers are responsible for coordinating care of the Hospice client and payment amounts.
- 4. The Hospice Provider is reimbursed for routine home care or continuous home care provided to clients residing in a NF or ICF/ID. If a client is eligible for Medicare and Medicaid and the client resides in a NF or ICF/ID, Medicare reimburses the Hospice Services, and Medicaid reimburses for Room and Board.
- 5. Reimbursement for date of discharge:
 - a. Reimbursement for date of discharge must be made at the appropriate home care rate for the day of discharge from general or respite inpatient care, unless the client dies at an inpatient level of care. When the client dies at an inpatient level of care, the applicable general or respite inpatient rate is paid for the discharge date.
 - b. Reimbursement for nursing facility and ICF/ID residents is made for services delivered up to the date of discharge when the client is discharged, alive or deceased, including applicable per diem payment for the date of discharge.

8.550.9.B. Reimbursement Limitations

- 1. Aggregate payment to the Hospice Provider is subject to an annual indexed aggregate cost cap. The method for determining and reporting the cost cap must be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Sections 418.308 and 418.309 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.
- 2. Aggregate days of care provided by the Hospice Provider are subject to an annual limitation of no more than 20 percent general and respite inpatient care days. The method for determining and reporting the inpatient days percentage shall be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Section 418.302 (2018). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Inpatient days in excess of the 20 percent limitation must be reimbursed at the routine home care rate.
- 3. The Hospice Provider must not collect co-payments, deductibles, cost sharing or similar charges from the client for Hospice Services including biological and respite care.
- 4. The Hospice Provider must submit all billing to the Medicaid fiscal agent within such timeframes and in such form as prescribed by the Department.
- 5. Specific billing instructions for submission and processing of claims is provided in the Department's Hospice billing manual.

8.551 REPEALED, EFFECTIVE FEBRUARY 1, 2014

8.552 IN HOME SUPPORT SERVICES

8.552.1 DEFINITIONS

- A. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS to a client and meets the qualifications as defined at 10 C.C.R 2505-10, § 8.552.6.K.
- B. Authorized Representative (AR) means an individual designated by the client, or by the parent or guardian of the client receiving services, if appropriate, who has the judgment and ability to assist the client in acquiring and receiving services as defined in C.R.S. Section 25.5-6-1202.
- C. Care Plan means a written plan of care developed between the client or the client's Authorized Representative, IHSS Agency and Case Management Agency that is authorized by the Case Manager.
- D. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.
- E. Extraordinary Care means a service which exceeds the range of care a Family Member would ordinarily perform in a household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the client and avoid institutionalization.
- F. Family Member means any person related to the client by virtue of blood, marriage, adoption, or common law.
- G. Health Maintenance Activities means those routine and repetitive skilled health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if they were physically able, or that would be carried out by Family Members or friends if they were available. These activities include any excluded Personal Care tasks as defined in 10 C.C.R 2505-10 § 8.489, as well as skilled tasks typically performed by a Certified Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment and judgement of a licensed nurse.
- H. Homemaker Services means general household activities provided in the home of an eligible client to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.
- I. Inappropriate Behavior means documented verbal, sexual or physical threats or abuse committed by the client or Authorized Representative toward Attendants, Case Managers, or the IHSS Agency.
- J. 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.

- K. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the client or client's Authorized Representative, including Health Maintenance Activities and support for activities of daily living or instrumental activities of daily living, Personal Care services and Homemaker services.
- L. 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.
- M. Licensed Medical Professional means the primary care provider of the client who possess one of the following medical licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN) as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.
- N. Personal Care means services which are furnished to an eligible client in the client's home to meet the client's physical, maintenance and supportive needs, when those services are not skilled Personal Care, do not require the supervision of a nurse, and do not require physician's orders.

8.552.2 ELIGIBILITY

8.552.2.A. To be eligible for IHSS a client shall meet the following criteria:

1. Be enrolled in a Medicaid program approved to offer IHSS.
2. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition stating that the client has sound judgment and the ability to self-direct care. If the client is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.
3. If a client is required by the Physicians Attestation to have an Authorized Representative or elects to have an Authorized Representative, the client must delegate an Authorized Representative who has the judgment and ability to assist the client in acquiring and using services, or
 - a. Obtain assistance from an IHSS Agency that is able and willing to support the client as necessary to participate in IHSS.

8.552.2.B. IHSS eligibility for a client will end if:

1. The client is no longer enrolled in a Medicaid program approved to offer IHSS.
2. The client's medical condition deteriorates causing an unsafe situation for the client or the Attendant as determined by the client's Licensed Medical Professional.
3. The client refuses to designate an Authorized Representative or receive assistance from an IHSS Agency when the client is unable to direct their own care as documented by the client's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.
4. The client provides false information or false records.

8.552.3 IHSS SERVICES

8.552.3.A. Services are for the benefit of the client. Services for the benefit of other persons are not reimbursable.

8.552.3.B. Services available for eligible adults:

1. Homemaker as defined at 10 C.C.R. 2505-10, § 8.490
2. Personal Care as defined at 10 C.C.R. 2505-10, § 8.489
3. Health Maintenance Activities

8.552.3.C. Services available for eligible children:

1. Health Maintenance Activities

8.552.4 CLIENT AND AUTHORIZED REPRESENTATIVE PARTICIPATION AND SELF-DIRECTION

8.552.4.A. A client or their Authorized Representative may self-direct the following aspects of service delivery:

1. Present a person(s) of their own choosing to the IHSS Agency as a potential Attendant. The client must have adequate Attendants to assure compliance with all tasks in the Care Plan.
2. Train Attendant(s) to meet their needs.
3. Dismiss Attendants who are not meeting their needs.
4. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.
5. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the client's Licensed Medical Professional.
6. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.
7. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.
8. Request a reassessment, as described at 10 C.C.R. 2505-10, § 8.393.2.D, if level of care or service needs have changed.

8.552.4.B. An Authorized Representative is not allowed to be reimbursed for IHSS Attendant services for the client they represent.

8.552.4.C. If the client is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:

1. Must be at least 18 years of age.
2. Must have known the client for at least two years. For children under the age of two, the Authorized Representative must have known the child for the duration of their life.

- 3. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.
- 8.552.4.D. The Authorized Representative must attest to the above requirement on the Authorized Representative Designation for In-Home Support Services (IHSS) form.
- 8.552.4.E. IHSS clients who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS client.
- 8.552.4.F. The client and their Authorized Representative must adhere to IHSS Agency policies and procedures.

8.552.5 IHSS AGENCY ELIGIBILITY

- 8.552.5.A. The IHSS Agency shall conform to all requirements set forth at 10 C.C.R. 2505-10, § 8.487.
- 8.552.5.B. The provider agreement for an IHSS Agency may be terminated, denied, or non-renewed pursuant to 10 C.C.R. 2505-10, § 8.076.5.

8.552.6 IHSS AGENCY RESPONSIBILITIES

- 8.552.6.A. The IHSS Agency shall assure and document that all clients are provided the following:
 - 1. Independent Living Core Services
 - a. An IHSS Agency must provide a list of the full scope of Independent Core Living Services provided by the agency to each client on an annual basis. The IHSS Agency must keep a record of each client's choice to utilize or refuse these services.
 - 2. Attendant training, oversight and supervision by a licensed health care professional employed by the IHSS who is at minimum a Registered Nurse (RN).
 - 3. The IHSS agency shall provide 24-hour back-up service for scheduled visits to clients at any time an Attendant is not available. At the time the Care Plan is developed the IHSS Agency shall ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.
- 8.552.6.B. The IHSS Agency shall adhere to the following:
 - 1. If the IHSS Agency admits clients with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the agency or have other effective back-up plans to ensure the needs of the client are met.
 - 2. The IHSS Agency shall only accept clients for care or services based on a reasonable assurance that the needs of the client can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.
 - a. There shall be documentation in the Care Plan or client record of the agreed upon days and times of services to be provided based upon the client's needs that is updated at least annually.

3. If an IHSS Agency receives a referral of a client who requires care or services that are not available at the time of referral, the IHSS Agency shall advise the client or their Authorized Representative and the Case Manager of that fact.
 - a. The IHSS Agency shall only admit the client if the client or their Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.
 4. The IHSS Agency shall ensure orientation is provided to clients or Authorized Representatives who are new to IHSS or request re-orientation through The Department's prescribed process. Orientation shall include instruction in the philosophy, policies and procedures of IHSS and information concerning client rights and responsibilities.
 5. The IHSS Agency will keep written service notes documenting the services provided at each visit.
- 8.552.6.C. The IHSS Agency is the legal employer of a client's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by The Department.
- 8.552.6.D. The IHSS Agency shall assist all clients in interviewing and selecting an Attendant when requested, and maintain documentation of the IHSS Agency's assistance and/or the client's refusal of such assistance.
- 8.552.6.E. The IHSS Agency will complete an intake assessment following referral from the Case Manager. The IHSS Agency will develop a Care Plan in coordination with the Case Manager and client. Any proposed services outlined in the Care Plan that may result in an increase in authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to start of services.
- 8.552.6.F. The IHSS Agency shall ensure that a current Care Plan is in the client's record, and that Care Plans are updated with the client at least annually or more frequently in the event of a client's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.
1. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope and duration of each service to be provided to the client for each day and visit. The Care Plan shall be signed by the client or the client's Authorized Representative and the IHSS Agency.
 2. In the event of the observation of new symptoms or worsening condition that may impair the client's ability to direct their care, the IHSS Agency, in consultation with the client or their Authorized Representative and Case Manager, shall contact the client's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the client's revised Care Plan, with the client and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval.
- 8.552.6.G. The IHSS Agency shall either contract with or employ a state-licensed health care professional, who is at the minimum a Registered Nurse (RN). The IHSS Agency's licensed health care professional is responsible for the following activities:

1. Administer a skills validation test for Attendants. Skills validation must be completed prior to service delivery unless postponed by the client or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS in the client's file. In no event shall the skills validation be postponed for more than 30 days after services begin to prevent interruption in services.
 2. Verify and document Attendant skills and competency to perform IHSS and basic client safety procedures.
 3. Counsel Attendants and staff on difficult cases and potentially dangerous situations.
 4. Consult with the client, Authorized Representative or Attendant in the event a medical issue arises.
 5. Investigate complaints and critical incidents within ten (10) calendar days as defined in 10 C.C.R 2505-10 § 8.487.15.
 6. Verify the Attendant follows all tasks set forth in the Care Plan.
 7. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the client, their Authorized Representative, or the Case Manager.
 8. Provide in-home supervision for the client as agreed upon by the client or their Authorized Representative.
- 8.552.6.H. At the time of enrollment and following any change of condition, the IHSS Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the client record.
1. The IHSS Agency shall collaborate with the client or client's Authorized Representative to determine the level of supervision provided by the IHSS Agency's licensed health care professional beyond the requirements set forth at C.R.S. Section 25.5-6-1203.
 2. The client may decline recommendations for in-home supervision. The IHSS Agency must document this choice in the client record and notify the Case Manager. The IHSS Agency and their licensed health care professional, Case Manager, and client or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.
- 8.552.6.I. The IHSS Agency shall assure and document that all Attendants have received basic training in the delivery of IHSS prior to the start of services. Attendant training shall include:
1. Development of interpersonal skills focused on addressing the needs of persons with disabilities.
 2. Overview of IHSS as a service-delivery option of consumer direction.
 3. Instruction on basic first aid administration.
 4. Instruction on safety and emergency procedures.
 5. Instruction on infection control techniques, including universal precautions.

6. Mandatory reporting procedures.
- 8.552.6.J. The IHSS Agency shall allow the client or Authorized Representative to provide individualized Attendant training that is specific to their own needs and preferences.
- 8.552.6.K. With the support of the IHSS Agency, Attendants must adhere to the following:
 1. Must be at least 18 years of age and demonstrate competency in caring for the client to the satisfaction of the client or Authorized Representative.
 2. May be a Family Member subject to the reimbursement and service limitations in 10 C.C.R. 2505-10, Section 8.552.8.
 3. Must be able to perform the assigned tasks on the Care Plan.
 4. Shall not, in exercising their duties as an IHSS Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse as defined in C.R.S. Section 25.5-6-1203.
 5. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.
- 8.552.6.L. The IHSS Agency shall provide functional skills training to assist clients and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

8.552.7 CASE MANAGEMENT AGENCY RESPONSIBILITIES

- 8.552.7.A. The Case Manager shall provide information and resources about IHSS to eligible clients, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.
- 8.552.7.B. The Case Manager will initiate a referral to the IHSS Agency of the client or Authorized Representative's choice, including an outline of approved services as determined by the Case Manager's most recent assessment. The referral must include the Physician Attestation, assessment information, and other pertinent documentation to support the development of the Care Plan.
- 8.552.7.C. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:
 1. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.
 2. If the client requires an Authorized Representative, the Authorized Representative Designation for In-Home Support Services (IHSS) form or In-Home Support Services (IHSS) Client and Provider Agency Responsibilities form must be completed.
- 8.552.7.D. Upon the receipt of the Care Plan, the Case Manager shall:
 1. Review the Care Plan in a timely manner to ensure there is no disruption or delay in the start of services.

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2. Ensure all required information is in the client's Care Plan and that services are appropriate given the client's medical or functional condition. If needed, request additional information from the client, their Authorized Representative, the IHSS Agency, or Licensed Medical Professional regarding services requested.
 3. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.
 4. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the client's eligible benefits.
 5. Collaborate with the client or their Authorized Representative and the IHSS Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.
 6. Authorize cost-effective and non-duplicative services via the prior authorization request (PAR). Provide a copy of the PAR to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.
 7. Work collaboratively with the IHSS Agency, client, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.
 - a. Case Manager will complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the client's rights to fair hearing, and appeal procedures.
- 8.552.7.E. The Case Manager shall ensure cost-effectiveness and non-duplication of services by:
1. Documenting the discontinuation of previously authorized agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by IHSS.
 2. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.
 - a. A client may receive services from multiple Attendants or agencies if appropriate for the client's level of care and documented service needs.
 3. Ensuring the client's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan, and requesting additional information as needed.
 4. Coordinating transitions from a hospital, nursing facility, or other agency to IHSS. Assisting client with transitions from IHSS to alternate services if appropriate.
 5. Collaborating with the client or their Authorized Representative and the IHSS Agency in the event of any change in condition. The Case Manager shall request an updated Physician Attestation of Consumer Capacity form. The Case Manager may revise the Care Plan as appropriate given the client's condition and functioning.
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6. Completing a reassessment if requested by the client as described at 10 C.C.R. 2505-10, § 8.393.2.D., if level of care or service needs have changed.
- 8.552.7.F. The Case Manager shall not authorize more than one consumer-directed program on the client's prior authorization request (PAR).
- 8.552.7.G. The Case Manager shall participate in training and consultative opportunities with The Department's Consumer-Directed Training & Operations contractor.
- 8.552.7.H. Additional requirements for Case Managers:
 1. Contact the client or Authorized Representative once a month during the first three months of receiving IHSS to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.
 2. Contact the client or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.
 3. Contact the client or Authorized Representative when a change in Authorized Representative occurs, and continue contact once a month for three months after the change takes place.
 4. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the agency, and supervision provided. The Case Manager must document and keep record of the following:
 - a. IHSS Care Plans;
 - b. In-home supervision needs as recommended by the Physician;
 - c. Independent Living Core Services offered and provided by the IHSS Agency; and
 - d. Additional supports provided to the client by the IHSS Agency.
- 8.552.7.I. Start of Services
 1. Services may begin only after the requirements defined at 10 C.C.R. 2505-10, § 8.552.2, 8.552.6.E., 8.552.6.I., and 8.552.7.C. have been met.
 2. The Case Manager shall establish a service period and submit a prior authorization request (PAR), providing a copy to the IHSS Agency prior to the start of services.

8.552.8 REIMBURSEMENT AND SERVICE LIMITATIONS

- 8.552.8.A. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and 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.
- 8.552.8.B. IHSS Personal Care services must comply with the rules for reimbursement set forth at 10 C.C.R. 2505-10 § 8.489.50. IHSS Homemaker services must comply with the rules for reimbursement set forth at 10 C.C.R. 2505-10 § 8.490.5.

- 8.552.8.C. Family Members are authorized to provide only Personal Care services or Health Maintenance Activities for eligible adults and Health Maintenance Activities for eligible children.
- 8.552.8.D. Services rendered by an Attendant who shares living space with the client or Family Members are reimbursable only when there is a determination by the Case Manager, made prior to the services being rendered, that the services meet the definition of Extraordinary Care.
- 8.552.8.E. Family Members shall not be reimbursed for more than forty (40) hours of Personal Care services in a seven (7) day period.
- 8.522.8.F. Health Maintenance Activities may include related Personal Care and Homemaker services if such tasks are completed during the Health Maintenance visit and are secondary and contiguous to the Health Maintenance Activity.
- 8.552.8.G. Restrictions on allowable Personal Care units shall not apply to parents who provide Attendant services to their eligible adult children under In-Home Support Services as set forth at 10 C.C.R. 2505-10 § Section 8.485.204.D.
- 8.552.8.H. The IHSS Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved PAR. The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.
- 8.522.8.I. The IHSS Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.
- 8.552.8.J. Services by an Authorized Representative to represent the client are not reimbursable. IHSS services performed by an Authorized Representative for the client that they represent are not reimbursable.
- 8.552.8.K. An IHSS Agency shall not be reimbursed for more than 24 hours of IHSS service in one day by an Attendant for one or more clients collectively.
- 8.552.8.L. A client cannot receive IHSS and Consumer Directed Attendant Support Services (CDASS) at the same time.
- 8.552.8.M. Independent Living Core Services, attendant training, and oversight or supervision provided by the IHSS Agency's licensed health care professional are not separately reimbursable. No additional compensation is allowable for IHSS Agencies for providing these services.

8.552.9 DISCONTINUATION AND TERMINATION OF IN-HOME SUPPORT SERVICES

- 8.552.9.A. A client may elect to discontinue IHSS or use an alternate service-delivery option at any time.
- 8.552.9.B. A client may be discontinued from IHSS when equivalent care in the community has been secured.
- 8.552.9.C. The Case Manager may terminate a client's participation in IHSS for the following reasons:
1. The client or their Authorized Representative fails to comply with IHSS program requirements as defined in 10 C.C.R. 2505-10 § 8.552.4, or

2. A client no longer meets program criteria, or
3. The client provides false information, false records, or is convicted of fraud, or
4. The client or their Authorized Representative exhibits Inappropriate Behavior and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.
 - a. The IHSS Agency and Case Manager are required to assist the client or their Authorized Representative to resolve the Inappropriate Behavior and to document all attempts to resolve the Inappropriate Behavior prior to notice of termination.

8.552.9.D. When an IHSS Agency discontinues services, the agency shall give the client and the client's Authorized Representative written notice of at least 30 days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice shall be considered given when it is documented that the client or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the Case Management Agency.

1. Exceptions will be made to the requirement for advanced notice when the IHSS Agency has documented that there is an immediate threat to the client, IHSS Agency, or Attendants.
2. Upon IHSS Agency discretion, the agency may allow the client or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

8.552.9.E. If continued services are needed with another agency, the current IHSS Agency shall collaborate with the Case Manager and client or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the client's safety and welfare.

8.552.9.F. In the event of discontinuation or termination from IHSS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for termination, information about the client's rights to fair hearing, and appeal procedures. Once notice has been given, the client or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.

8.553 COMMUNITY TRANSITION SERVICES

8.553.1 DEFINITIONS

Authorization Request (AR) means a request submitted by the Transition Coordination Agency to the Single Entry Point agency to authorize payment for delivery of Community Transition Services.

Case Management means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic assessment of such client's needs.

Case Management Agency means the organization selected to provide case management functions for person in need of long term care services.

Community Transition Services (CTS) means activities essential to move a client from a skilled nursing facility and establish a community-based residence.

Independent Living Core Services means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; and individual and systems advocacy.

Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Case Management.

Transition Coordination Agency (TCA) means an agency that is certified by the Department to provide CTS and provides at least two Independent Living Core Services.

Transition Options Team means a group of individuals, chosen by the client and/or providing services to the client, who participate in the transition assessment and planning process.

8.553.2 BENEFITS

8.553.2.A. CTS shall only be available to clients currently residing in a skilled nursing facility or an Intermediate Care Facility-Individuals with Intellectual Disabilities (ICF-IID) who are eligible for adult Home and Community- Based Services (HCBS) waivers except the Spinal Cord Injury Waiver.

8.553.2.B. CTS includes transition coordination services and funds to assist the client to set-up a household.

8.553.2.C. CTS shall be provided by Transition Coordinators who are employed by Transition Coordination Agencies certified by the Department.

8.553.2.D. CTS shall be provided using procedures and guidelines provided in the Department transition coordination and intensive case management training.

8.553.2.E. The CTS household set-up assistance shall only be for the benefit of the client to set up a less restrictive living arrangement and may include the following:

1. Security deposits that are required to obtain a lease on a residence.
2. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.
3. Essential household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items.
4. Moving expenses required to occupy a community-based residence.
5. Health and safety assurances including a one-time pest eradication and one-time cleaning prior to occupancy.
6. A one-time purchase of food not to exceed \$100.
7. Purchase of a cell phone to be used for safety monitoring.
8. First month rent.

9. Bus pass for period that covers the time period from referral to CTS to 30 days past the date of discharge from a facility described at 10 C.C.R. 2505-10, Section 8.553.2.A.
10. Computer that is determined to be medically necessary to sustain a less restrictive living arrangement. (Client is required to complete computer training prior to receiving computer).
11. Clothing that is appropriate for the community.

8.553.2.F. The cost of CTS shall not exceed the established amount per client unless otherwise authorized by the Department.

8.553.2.G. Items purchased through CTS, returned security deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.a. and returned deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.b. shall be the property of the client. The client may take the property with him or her in the event of a move to another residence.

8.553.3 NON-BENEFITS

8.553.3.A. CTS shall not include the following:

1. Monthly rental expenses or other ongoing periodic residential expenses.
2. Recreation, entertainment or convenience items.
3. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.E when already provided through other means.
4. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.E when provided for the benefit of persons other than the client.
5. Monthly cell phone expenses.
6. Monthly bus pass expenses not described in 10 C.C.R. 2505-10, Section 8.553.2.E.i.

8.553.4 TCA QUALIFICATIONS

8.553.4.A. A TCA shall conform to all certification standards and procedures described in 10 C.C.R. 2505-10, Section 8.487, HCBS-EBD Provider Agencies.

8.553.4.B. A TCA shall meet all requirements as set forth in 10 C.C.R. 2505-10, Section 8.553.5.

8.553.5 TCA RESPONSIBILITIES

8.553.5.A. TCAs shall administer the CTS benefit.

8.553.5.B. The TCA shall perform administrative functions, including supervision of Transition Coordinators, attendance at required meetings, timely reporting, compliance with transition procedures defined by the Department with input from stakeholders, community coordination and outreach, client monitoring and on-site visits.

8.553.5.C. Staffing Requirements

1. The TCA shall ensure and document that each Transition Coordinator has completed the required Department Transition Coordinator training and has received a satisfactory proficiency rating.
2. The TCA shall ensure that each Transition Coordinator has received training in the following:
 - a. Knowledge of populations served by the TCA and the target population served by waivers.
 - b. Client interviewing and assessment skills.
 - c. Intervention and interpersonal communication skills.
 - d. Knowledge of available community resources and public assistance programs.
 - e. Team coordination skills.
 - f. Meeting facilitation skills.
3. The TCA supervisor(s), at a minimum, shall have two years supervisory experience and meet all qualifications for a Transition Coordinator.
4. The TCA supervisor shall complete the Department transition coordination supervision training.
5. Supervision of Transition Coordinators shall include, but not be limited to, the following activities:
 - a. Arrangement and documentation of training or skills validation testing.
 - b. Review of transition assessments and plans and risk mitigation plans.
 - c. Oversight of transition coordination activities.
 - d. Assessment of client's satisfaction with services.
 - e. Investigation of complaints regarding provision of CTS.
 - f. Counseling with staff on difficult cases.
 - g. Oversight of recordkeeping by staff.
6. Training shall be completed prior to the delivery of CTS.

8.553.5.D. The Transition Coordinator shall conduct transition activities in accordance with training, policies and procedures defined by the Department.

8.553.5.E. The Transition Coordinator shall work with the client to create and implement a transition plan agreed upon by the Transition Coordinator and the client. The Transition Coordinator and the client shall sign the transition plan to signify agreement.

1. The Transition Coordinator shall submit the signed transition plan to the client's Single Entry Point (SEP) case manager for approval prior to plan implementation.
2. The plan shall include the items needed for the client to transition to a community-based residence. If after the plan has been approved the Transition Coordinator determines additional purchases are required, the Transition Coordinator shall submit a plan revision for approval prior to the purchases.

8.553.5.F. The Transition Coordinator shall work with the client to obtain a residence and any items necessary to establish a community-based residence.

8.553.5.G. The Transition Coordinator shall conduct a minimum of four on-site visits of the residence to ensure all essential furnishings, utilities, community resources and services are in place. If the Transition Coordinator finds any of the supports to be insufficient for the client to successfully live in the community, the Transition Coordinator shall correct the deficiencies. The on-site visits shall occur at the following intervals:

1. Prior to the client's discharge from the skilled nursing facility.
 - a. If possible, the client shall accompany the Transition Coordinator during the on-site visit prior to discharge. If the client is unable to participate in the on-site visit, the Transition Coordinator shall document the reason in the client's file.
2. The day of the move.
3. One week after the transition to ensure the client has the proper supports to continue successfully living in the community.
4. One month after the transition to ensure the client has the proper supports to continue successfully living in the community.

8.553.6 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES

8.553.6.A. The SEP case manager shall perform a review to assure all items in the transition plan meet the criteria of the benefit described in 8.553.2.

1. The SEP case manager shall complete a review of the transition plan and shall notify the TCA of approval or denial of the plan within ten business days of receipt.

8.553.7 AUTHORIZATION REQUESTS

8.553.7.A. The TCA shall submit the Department prescribed Authorization Request (AR) form to the SEP case manager to authorize payment for CTS.

1. The TCA shall only submit the AR to authorize payment for any purchases or deposits after the client transitions to the community. The AR shall include a Department-approved cost report including copies of cancelled checks and copies of receipts detailing the items purchased and the cost.
 - a. Any expenses submitted on the cost report for items that are not included in the approved transition plan shall be considered non-allowable expenses and shall not be reimbursed.

- b. The SEP case manager shall complete a review of the AR and the cost report and shall notify the TCA of approval or denial of the AR and if applicable, any non-allowable expenses on the cost report within ten business days of receipt.
- 2. The TCA shall only submit the AR for Transitional Case Management once the Transition Coordinator has conducted the on-site visit one month after the client's transition.
 - a. The SEP case manager shall approve the AR only after verifying that the client is established in a community-based residence.
 - b. The SEP case manager shall complete a review of the AR and shall notify the TCA of approval or denial within ten business days of receipt.
- 8.553.7.B. The SEP case manager shall complete a review of the AR and the cost report within ten business days of receipt. The SEP case manager shall notify the TCA of approval of the AR and if applicable, any non-allowable expenses on the cost report.
 - 1. Approval of the AR by the SEP case manager shall authorize the TCA to submit claims to the Department's fiscal agent for authorized CTS provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the TCA's use of correct billing procedures.
- 8.553.7.C. Incomplete ARs shall be returned to the TCA for correction within ten business days of receipt by the SEP agency.

8.553.8 REIMBURSEMENT

- 8.553.8.A. The TCA shall conform to all reimbursement procedures described in 10 C.C.R. 2505-10, Section 8.487.200 Provider Reimbursement.
- 8.553.8.B. Payment for CTS shall be the lower of the billed charges or the maximum rate of reimbursement.
- 8.553.8.C. The cost of Transitional Case Management shall be reimbursed by one unit of service completed when the client is established in a community-based residence as verified by the SEP case manager.
- 8.553.8.D. Reimbursement shall be made only for items listed on the transition plan with an accompanying receipt.

8.555 COLORADO CHOICE TRANSITIONS (CCT), A MONEY FOLLOWS THE PERSON DEMONSTRATION

8.555.1 DEFINITIONS OF DEMONSTRATION SERVICES PROVIDED

Assistive Technology, Extended means devices, items, pieces of equipment, or product system used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.

Caregiver Education means educational and coaching services that assist clients and family members with managing the stress of caregiving and to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.

Community Transition Services means services as defined at 10 CCR 2505-10, Section 8.553.

Dental Services means dental services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health and not available through the Medicaid State Plan.

Enhanced Nursing means medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers.

Home Delivered Meals means nutritious meals delivered to homebound clients who are unable to prepare their own meals and have no outside assistance.

Home Modifications, Extended means physical adaptations to the home, required by the client's plan of care, necessary to ensure the health, welfare, safety and independence of the client above and beyond the cost of caps that exist in applicable Home and Community-Based (HCBS) waivers.

Independent Living Skills Training means services designed to improve or maintain a client's physical, emotional, and economic independence in the community with or without supports.

Intensive Case Management means case management services to assist clients' access to needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition goals.

Peer Mentorship Services means services provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world experiences as example and modeling successful community living and problem-solving.

Transitional Behavioral Health Supports means services by a paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.

Vision Services means services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan.

8.555.2 GENERAL DEFINITIONS

Demonstration services means services unique to the CCT program and provided during a client's enrollment in the demonstration program.

Medically complex means one or more medical conditions that are persistent and substantially disabling or life threatening and meets the following conditions:

1. Requires treatment and services across a variety of domains of care;
2. Is associated with conditions that have severe medical or health-related consequences;
3. Affects multiple organ systems;
4. Requires coordination and management by multiple specialties; and
5. Treatments carry a risk of serious complications.

Paraprofessional means a person with a Bachelor's Degree in psychology, social work or other human service related field who is employed by a mental health provider; is supervised by a Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Psychologist; and has experience with facilitating the implementation of a behavioral management plan among families, a client, providers and other members of a support system for the client.

Qualified institution means a nursing facility; intermediate care facilities for people with intellectual disabilities (ICF/ID); or institutions for mental diseases (IMDs), which include Psychiatric Hospitals only to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

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

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

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

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

8.555.3 LEGAL BASIS

The Colorado Choice Transitions (CCT) program is created through a Money Follows the Person (MFP) grant award authorized by section 6071 of the Deficit Reduction Act of 2005. Section 2403 of Patient Protection and Affordable Care Act extended the program through September 30, 2016. The United States Department of Health and Human Services awarded the MFP demonstration grant to Colorado. This demonstration program is administered by the Centers for Medicare and Medicaid Services (CMS). The MFP statute provides waiver authority for four provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of the demonstration. These provisions are:

1. Statewideness (Section 1902(a)(1)) - in order to permit implementation of a State initiative in a selected area or areas of the State.
2. Comparability (Section 1902(a)(10)(B) - in order to permit a State initiative to assist a selected category or categories of individuals enrolled in the demonstration.
3. Income and Resource Eligibility (Section 1902(a)(10)(C)(i)(III) – in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.
4. Provider agreement (Section 1902(a)(27)) - in order to permit a State to implement self-direction services in a cost-effective manner for purposes of this demonstration program.

CCT is designed to complement the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD); Home and Community Based Services for People with Brain Injury (HCBS-BI); Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS); Home and Community Based Services for the Developmentally Disabled (HCBS-DD); and Home and Community Based Services for Supported Living Services (HCBS-SLS) programs. These waivers are authorized through Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n).

8.555.4 SCOPE AND PURPOSE

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

8.555.4.B. The CCT program strengthens the transition process for residents of qualified institutions and provides additional supports and services for a successful transition. These additional supports and services are called demonstration services.

8.555.4.C. Clients may be enrolled in the CCT program for 365 days. Days in a hospital or other qualified institution for a period of less than 30 days during the enrollment period will not count towards the 365 days.

8.555.4.D. CCT clients will be concurrently enrolled in the CCT program and one of the following waivers:

1. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) (10. C.C.R. 2505-10, Section 8.485);
2. Home and Community Based Services for People with Brain Injury (HCBS-BI) (10 CCR 2505-10, Section 8.515.00);
3. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) (10 CCR 2505-10, Section 8.509);
4. Home and Community Based Services for the Developmentally Disabled (HCBS-DD) (10 CCR 2505-10, Section 8.500); and
5. Home and Community Based Services for Supported Living Services (HCBS-SLS) (10 CCR 2505-10, Section 8.500.90).

8.555.4.E. At the end of the 365 day enrollment period for the CCT program, case managers will disenroll clients from the program.

1. Demonstration services will terminate at the end of the 365 days of CCT enrollment period.
2. After CCT concludes, if clients continue to meet eligibility requirements for one of the waivers listed in 8.555.4.D.case managers will arrange for the continuation of qualified HCBS services through the appropriate waiver.

8.555.5 CLIENT ELIGIBILITY

8.555.5.A. ELIGIBLE PERSONS

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

1. Clients shall be aged 18 years or older.
2. Clients shall have resided in a qualified institution for a period of 90 days. Days in a nursing facility for a rehab stay will not count towards the 90 days.
3. Clients shall be enrolled in Medicaid for at least one day prior to transition from a qualified institution.
4. Clients shall reside in a qualified residence post-transition.
5. Clients shall meet criteria of a targeted population which includes persons with mental illness, brain injury, physical disabilities or intellectual disabilities and the elderly.
6. Clients shall meet the eligibility requirements for the appropriate HCBS waiver programs listed in Section 8.555.4.D. in which they will be enrolled post-transition.
7. Clients concurrently enrolled in the HCBS-BI program and CCT shall be in the age range of 18-64 rather than 16-64 as specified in the HCBS-BI eligibility requirements.

8.555.5.B. FINANCIAL ELIGIBILITY

Clients must meet the financial eligibility requirements specified at 10 CCR 2505-10, Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.555.5.C. LEVEL OF CARE CRITERIA

Clients shall require long term support services at a level comparable to services typically provided in a nursing facility or ICF/ID in accordance with the waiver to which they will enroll upon transition.

8.555.5.D. NEED FOR CCT SERVICES

1. Only clients who have agreed to accept demonstration and qualified services as soon as all other eligibility criteria have been met are eligible for the CCT program.
 - a. Case management shall not be used to satisfy the requirement that a HCBS service must be received within 30 days.
 - b. The desire or need for any Medicaid services other than CCT demonstration services, as listed at Section 8.555.1, or qualified services offered through one of the waiver programs listed in Section 8.555.4.D. shall not satisfy this eligibility requirement.
2. Once enrolled, clients who have not received demonstration or qualified services for a period greater than 30 consecutive days shall be discontinued from the program.

8.555.5.E. EXCLUSIONS

1. Clients who are residents of nursing facilities, other qualified institutions or hospitals are not eligible to receive CCT or waiver services in preparation for discharge except for but not limited to transition coordination, case management, peer mentorship, independent living skills training, and/or enhanced nursing services.
2. CCT clients readmitted to a qualified institution or hospital may not receive CCT services while admitted except for transition coordination or case management services in preparation for discharge.
 - a. CCT clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the CCT program but may have the option to re-enroll upon discharge provided they continue to meet all eligibility requirements. The state has the right to exempt the 30 day exclusion on a case-by-case basis.
 - b. CCT clients entering a nursing facility for Respite Care as a qualified HCBS waiver service shall not be discontinued from the CCT program.
3. Clients who reside in a residence that is not a qualified residence as defined in Section 8.555.2 are not eligible for CCT services.
4. Demonstration services may not be available to clients for certain waivers if those demonstration services are similar to or are the same as services already offered through the state plan or HCBS waiver in which the client will enroll..

8.555.5.F. COST CONTAINMENT AND SERVICE ADEQUACY

1. The client shall not be eligible for the CCT program if:
 - a. The Department or its agent determines that the client's needs cannot be met within the specific cost containment requirements set for the HCBS waiver in which they will enroll..
 - b. The transition assessment reveals that the client's needs are more extensive than CCT demonstration services and/or HCBS qualified or state plan services are able to support and/or that the client's health and safety cannot be reasonably assured in a community setting.
2. In the event that the Department or its agent denies or reduces the request for services prior to transition, the case manager shall provide the client with the client's appeal rights pursuant to Section 8.555.12.
3. The client may be eligible for continuation with an HCBS waiver program following the CCT enrollment period if the case manager at reassessment determines that qualified services are able to support the client's needs and the client's health and safety can be assured in a community setting with HCBS services.
 - a. If the case manager expects that the services required to support the client's needs will exceed the cost containment requirements for the waiver in which the client is enrolled, the Department or its agent will review the service plan to determine if the client's request for services is appropriate and justifiable based on the client's condition.

- i) The client may request of the case manager that existing qualified services remain intact during this review process. CCT demonstration services will still end on the 365th day of the client's enrollment in the CCT program.
- ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the client with:
 - 1) The client's appeal rights pursuant to Section 8.555.12; and
 - 2) Alternative options to meet the client's needs that may include, but are not limited to, nursing facility or ICF/ID placement.

8.555.6 CCT ENROLLMENT

- 8.555.6.A. Clients and legal guardians, if appointed, shall demonstrate by signature that he or she provides consent to participate in the CCT demonstration program; understands the roles and responsibilities of the client, case manager and transition coordinator; and agrees to participate in the program evaluation activities. If there is a dispute between the client and the guardian regarding participation in the CCT program, the dispute shall be resolved in accordance with guardianship statutes and regulations.
- 8.555.6.B Transition coordinators and case managers will ensure that clients meet all eligibility requirements identified in Section 8.555.5 prior to enrollment.
- 8.555.6.C. Transition coordinators shall facilitate the completion of the Department approved Transition Assessment/Plan for each client with the support of the transitions options team members.
- 8.555.6.D. Transition coordinators and case managers will follow all policies and procedures defined by the state and made available through trainings and other guidance.
- 8.555.6.E. Transition coordinators shall act in accordance with Department guidance and the requirements established in 10 C.C.R. 2505-10, Section 8.553.

8.555.7 START DATE FOR SERVICES

- 8.555.7.A. The start date of eligibility for CCT services shall not precede the date that all of the requirements at Section 8.555.5 have been met.
- 8.555.7.B. The first date for which CCT services may be reimbursed shall be the date of discharge from a qualified institution.
- 8.555.7.C. Transition coordination services and case management services may be offered prior to the client's transition in preparation of the transition to a community setting. Other services may be provided pre-transition with Departmental approval if the service is necessary for transition. Services shall be billed retroactively upon the date of discharge or up to 120 days after discharge.

8.555.8 CASE MANAGEMENT FUNCTIONS

- 8.555.8.A. The requirements at 10 CCR 2505-10, Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the CCT program and the HCBS-EBD, HCBS-CMHS or HCBS-BI waiver programs. Case managers for these waivers shall comply with these requirements and the CCT-specific requirements in the rest of this section.

8.555.8.B. The requirements at 10 CCR 2505-10, Section 8.760 shall apply to the Case Management Agencies performing the case management functions of the CCT program and the HCBS-SLS or HCBS-DD programs. Case managers for these waivers shall comply with these requirements and the CCT-specific requirements in the rest of this section.

8.555.8.C. The case manager is responsible for:

1. Assessing needs;
2. Determining CCT and waiver program eligibility;
3. Service planning and authorization;
4. Arranging services;
5. Identifying potential risks for reinstitutionalization;
6. Implementing strategies with the client and family to mitigate risks;
7. Monitoring services;
8. Monitoring the health, welfare and safety of the client; and
9. Promotion of client's self-advocacy.

8.555.8.D. The case manager shall administer the first Quality of Life (QoL) Survey (baseline survey) within 14 days prior to the participant's transition to community living. For surveys conducted at 11 and 24 months following transition, the Department will send a survey request to the case management agencies (CMA) in the area where the survey needs to be completed. Once assigned, the interviewer from a CMA will schedule a time with the client and/or his or her proxy in the month that the survey is due and submit results to the Department.

8.555.8.E. The case manager shall conduct a home visit with the transition coordinator on the date of discharge to::

1. Confirm the start of services;
2. Ensure clients are safe; and
3. Identify and address any unanticipated concerns, issues and problems clients may have with the transition.

8.555.8.F. The case manager shall conduct a check-in with the client by phone 48 hours after discharge and conduct any necessary follow-up activities needed.

8.555.8.G. The case manager shall conduct three additional home visits in the first month that clients are enrolled in the program to provide support for success with community living.

8.555.8.H. The case manager shall tailor the frequency of contacts to the individual needs of the clients. Regular contacts, with clients, family members, guardians or other designated representatives for the duration of their enrollment in the CCT program to monitor services and the health, welfare and safety of the clients; and to conduct any necessary follow-up activities necessary to ensure independent living in the community is expected. The Department prefers that within the first few months post-transition that the case manager shall have a minimum of weekly contacts.

Contacts may either be phone contacts or home visits based on necessity.

8.555.8.I. The case manager shall revise the service plan, risk mitigation plan, and emergency back-up plan as needed based on the weekly contacts or as otherwise needed due to change in the client's condition.

8.555.8.J. The case manager shall review the client's most recent ULTC 100.2 and update the ULTC 100.2 assessment if a change in functional status or a significant change impacting eligibility has occurred, in accordance with 10 CCR 2505-10, Section 8.401.1.

8.555.8.K. The case manager shall begin preparing clients for dis-enrollment from the CCT program 90 days prior to the end of the clients' CCT enrollment period and arrange for the continuation of HCBS services if the clients continue to meet the eligibility requirements for a waiver listed at 8.555.4.D.

8.555.9 SERVICE PLAN

8.555.9.A. The service plan will be developed with input from the transition coordinator, staff from the discharging facility, the resident wanting to transition and others at the invitation of the client or guardian.

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

8.555.9.C. The service plan shall:

1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver qualified services, CCT demonstration services or through other means;
2. Identify risks to reinstitutionalization and outline a contingency plan identifying paid and unpaid supports and services necessary to mitigate the risk.
3. Be in accordance with the rules, policies and procedures related to service plans established by the Division for Developmental Disabilities if clients are enrolled in the HCBS-SLS (10 CCR 2505-10, Section 8.500.95) or -DD waivers (10 CCR 2505-10, Section 8.500.6);
4. Be in accordance with the rules, policies and procedures established related to service plans by the Department of Health Policy and Financing for clients enrolled in the HCBS-EBD (10 CCR 2505-10, Section 8.486.51), -CMHS (10 CCR 2505-10, Section 8.509.31.D.) or -BI waivers (10 CCR 2505-10, Section 8.516.30.);
5. Include updates and revisions when warranted by changes in the client's needs or conditions.

8.555.9.D. The service plan shall document that the client has been offered a choice:

1. Between community-based services or institutional care;
2. Between the CCT Program or a traditional HCBS Waiver;
3. Among qualified and demonstration services; and
4. Among qualified providers.

8.555.9.E. A new service plan will be developed each time a client is reinstitutionalized and plans to return to a community setting. The service plan shall address the reasons for the client's reinstitutionalization.

8.555.10 PROVIDER REIMBURSEMENT

8.555.10.A. All CCT demonstration and qualified services must be prior authorized by the Department or its agent.

8.555.10.B. The Department shall develop the Prior Authorization Request (PAR) form to be completed by case managers who shall comply with all applicable regulations when completing the form.

8.555.10.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the client's documented medical condition and functional capacity;
2. Reasonable in amount, scope, frequency, and duration;
3. Not duplicative of the other services included in the client's service plan;
4. Not for services for which the client is receiving funds to purchase; and
5. Do not total more than 24 hours per day of care.

8.555.10.D. The services requested on the PAR must meet all criteria listed at 8.555.10.C for the Department or its agent to approve the request.

8.555.10.E. If the Department or its agent determines that the services requested on the PAR do not meet the criteria at 8.555.10.C., the Department or its agent shall deny the PAR and work with the case management agency to submit a revised request.

1. If services are reduced or denied through a revised PAR, the case manager shall provide the client with the client's appeal rights pursuant to Section 8.555.12.

8.555.10.F. The prior authorization of services does not constitute an entitlement to those services, and does not guarantee payment.

8.555.10.G. The PAR start date shall not precede the start date of CCT eligibility in accordance with Section 8.555.7.

8.555.10.H. The PAR end date shall not exceed the end date of the initial CCT enrollment period, which cannot exceed 365 calendar days.

8.555.10.I. Revisions to the PAR that are requested six months or more after the end date of CCT enrollment shall be disapproved.

8.555.10.J. Prior to the end date, case managers shall establish a new CCT enrollment period and create a new PAR to reflect any days during the initial enrollment period that a client entered a hospital, nursing home, ICF/ID or other long term care institution for a period less than 30 days to ensure the client has a full 365 days of CCT enrollment in the community.

1. The numbers of days for the new enrollment period and PAR shall be equal to the numbers of days that the client was placed in an institution and shall commence on the first day after the end date of the initial enrollment period.

- 8.555.10.K. Prior Authorization Requests for clients enrolled in the HCBS-DD waiver shall be completed in accordance with Section 8.500.12
- 8.555.10.L. Prior Authorization Requests for clients enrolled in the HCBS-SLS waiver shall be completed in accordance with Section 8.500.101.
- 8.555.10.M. The PAR for qualified and demonstration services shall be sent to the Department or its agent for approval.
- 8.555.10.N. Approval of the PAR by the Department shall authorize providers of CCT services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. However, a PAR does not guarantee payment.
- 8.555.10.O. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.
- 8.555.10.P. Payment for CCT Services
1. Payment for CCT services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.
 - a. Rates for, Caregiver Education, Community Transition Services, Enhanced Nursing,, Home Delivered Meals, Extended, Independent Living Skills Training, Intensive Case Management, Peer Mentorship Service, , and Transitional Behavioral Health Supports are reimbursed on a fee-for-service basis and payment is based on the rate for each service found on the Departments statewide fee schedule.
 - b. The statewide fee schedule for these services are reviewed annually and published in the provider billing manual.
 - c. Payment for the following services is reimbursed at billed cost but cannot exceed the Department's established maximums: Assistive Technology, Extended, Dental Services, Home Modifications, Extended, and Vision services..
 2. Payment for CCT services is also conditional upon:
 - a. The client's eligibility for CCT services;
 - b. The provider's certification status; and
 - c. The submission of claims in accordance with proper billing procedures.

8.555.11 PROVIDER AGENCIES

- 8.555.11.A. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-EBD, -BI, or -CMHS shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.487.
- 8.555.11.B. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-DD shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.500.9.

8.555.11.C. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-SLS shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.500.98.

8.555.11.D. CCT providers of specific demonstration services must:

1. Conform to all state established standards for the specific services they provide under this program.
2. Abide by all the terms of their provider agreement with the Department; and
3. Comply with all applicable federal and state statutes, regulations and guidance
4. A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services

8.555.12 APPEAL RIGHTS

8.555.12.A. Case management agencies shall follow the rules for notification and appeals established for the waiver in which the client will enroll upon discharge.

1. For clients enrolled on HCBS-EBD, -BI and -CMHS, the case management agencies or utilization review contractor shall provide notification of adverse actions and appeals rights in accordance with 8.393.28.A.
2. For clients enrolled on HCBS-DD, the case management agencies shall provide notification of adverse actions and appeal rights in accordance with 8.500.16.
3. For clients enrolled on HCBS-SLS, the case management agencies shall provide notification of adverse actions and appeal rights in accordance with 8.500.106.

8.560 CLINIC SERVICES – CERTIFIED HEALTH AGENCIES

Clinic Services rendered by certified health agencies shall be a benefit of the Colorado Medical Assistance Program for categorically eligible individuals.

8.560.1 DEFINITIONS

For the purposes of this Section 8.560, the following definitions shall apply:

- A. Certified health agency: a county/district health department, regional health department or local board of health established pursuant to part 5, 6, or 7 of article 1 of title 25, C.R.S., that is certified by the Colorado State Department of Health.
- B. Nurse/Nurse practitioner: a registered professional nurse who is currently licensed to practice in the State of Colorado and who meets the qualifications established by the Nurse Practice Act.
- C. Nurse-midwife: a registered professional nurse currently licensed to practice in the State of Colorado who meets the following requirements: is certified as a nurse-midwife by the American College of Nurse-Midwives; is authorized under state statute to practice as a nurse-midwife; and whose services are rendered pursuant to the Colorado Medical Practice Act.

- D. Physician assistant/child health associate: a certified individual who performs under the supervision of a physician and meets the qualifications of the Colorado State Board of Medical Examiners.
- E. Physician: a doctor of medicine, osteopathy, legally authorized to provide medicine or surgery in Colorado.
- F. Medicaid primary care physician: a physician enrolled in the Primary Care Physician Program under the Colorado Medical Assistance Program.
- G. Visit: a face-to-face encounter between a clinic patient and nurse/nurse practitioner/nurse-midwife, physician assistant/child health associate, or physician providing services reimbursable under the Medicaid Program. If a patient sees more than one health professional, or meets more than once with the same health professional, on the same day and at a single location, this shall be counted as one visit.

8.561 REQUIREMENTS FOR CERTIFICATION

- A. Participating health agencies must be certified by the Colorado State Department of Health in accord with federal regulations 42 CFR 431.610, October 1991 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Manager, Health and Medical Services, Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203-1714. Certified health agencies performing laboratory services must be certified as a clinical laboratory in accordance with regulations cited at 8.660 through 8.666. Certified health agencies must obtain a certificate of waiver from the Health Care Financing Administration or its designated agency if the health agency only performs waived tests as defined by Clinical Laboratory Improvement Amendments of 1988 (CLIA).
- B. All certified health agencies and staff shall comply with all applicable federal, state and local regulations concerning the operation of such clinic services. These include but are not limited to the following: certification, organization, staffing, licensure of personnel, service provision responsibilities, maintenance of health records and program evaluation.
- C. Termination of certification or non-renewal of certification will be determined by the Colorado State Department of Health.

8.562 REQUIREMENTS FOR PARTICIPATION

Health agencies providing clinic services must be certified by the Colorado State Department of Health, must enroll in the Medical Assistance Program and provide proof of their certification status in order to participate under Medicaid. The certification document must be attached to the Medical Assistance enrollment form. Medical Assistance enrollment and/or reimbursement cannot be accomplished without proof of certification on file with the State's fiscal agent for the effective date of enrollment and date of service for which reimbursement is claimed.

8.563 BENEFITS AND LIMITATIONS

Clinic Services are a benefit of the Medical Assistance Act in Colorado when:

- A. The services are benefits of the Colorado Medicaid Program as determined by the Colorado State Department of Social Services;
- B. The services which are performed are medically necessary;
- C. The services are provided by certified health agencies;

- D. The services which are performed are within the scope of the providers' Medical and/or Nurse Practice Acts;
- E. The services are provided by a registered nurse, qualified nurse practitioner, or certified nurse-midwife or by a physician or physician's assistant (including child health associates) certified by the Colorado State Board of Medical Examiners;
- F. The services provided are obstetrical services which are benefits of the Medicaid program; or
- G. The services provided are EPSDT medical screening services which meet the requirements set forth in sections 8.285.02 through 8.287.01.

8.564 BILLING PROCEDURES

- A. Certified health agencies providing clinic services must bill the Medical Assistance Program directly using the designated billing method and the prescribed procedure codes recognized by the Colorado State Department of Social Services. The amount of the provider's usual and customary charges to the general public will be billed if applicable.
- B. Obstetrical services and adjunctive services, except for EPSDT medical screenings, must be billed directly as described in 10 C.C.R. 2505-10, Section 8.040.2.
- C. EPSDT medical screening services must be billed directly on the EPSDT Screening/Claim Form.

8.565 REIMBURSEMENT

Reimbursement shall be made according to the following:

- A. Payment for benefit services shall be in accord with the physician reimbursement policies as cited in Section 8.200 et seq.
- B. Each certified health agency will be reimbursed for only those services performed for which it is certified and for only one visit per recipient per day.
- C. Reimbursement for injectable vaccines obtained through the Infant Immunization Program is limited to the maximum allowed administrative fee.
- D. A health agency must be certified on any date for which reimbursement is being claimed. If reimbursement is claimed for a date of service on which the health agency is not certified, reimbursement shall be denied.

8.566 APPEALS

Provider grievances and appeals, resulting from State actions under this section of regulations, shall be handled in accordance with existing appeals regulations delineated in Sections 8.049 through 8.051.44.

8.567 CERTIFIED HEALTH AGENCY/PHYSICIAN RELATIONSHIP

- A. Obstetrical services require referral from the Medicaid Primary Care (PCP) or "Lock-In" physician. The certified agency will contact the PCP to obtain the appropriate referral for obstetrical services.
- B. EPSDT medical screenings require referral from the Medicaid Primary Care (PCP) or "Lock-In" physician. The certified agency will contact the PCP to obtain the appropriate referral for EPSDT Medical screening services.

- C. Medical support and approval for the policies and procedures of the local certified health agency's Well Child Clinics and Prenatal Clinics may be provided by the agency health officer, medical director or other physician (pediatrician, family practitioner or obstetrician) agreed upon by the public health nursing staff and their health officer. A physician must sign and annually review the agency's emergency procedures for reactions to biologicals.
- D. The certified health agency shall assure that a physician is available during agency hours by direct means of communication for assistance in emergencies and for consultation and referral if medical diagnosis and/or treatment is needed. This requirement may be satisfied by agreements with one or more physicians. Whenever possible, the certified health clinic practitioner will interact with the client's primary care physician when medical consultation is needed and will provide the primary care physician a copy of each EPSDT medical screening and obstetrical service record.

8.570 AMBULATORY SURGERY CENTERS

8.570.1 DEFINITIONS

Ambulatory Surgery Center (ASC) means an entity that operates exclusively for the purpose of furnishing surgical services for its clients that do not require hospitalization. An ASC may be independent or part of a hospital, but only if the building space utilized by the ASC is physically, administratively, and financially independent and distinct from other operations of the hospital.

CMS means the Centers for Medicare and Medicaid Services.

The Department refers to the Colorado Department of Health Care Policy and Financing.

Inpatient Basis in Hospitals means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by the Hospital for the care and treatment of inpatients and are provided in the Hospital by or under the direction of the physician.

8.570.2 REQUIREMENTS FOR PARTICIPATION

- 8.570.2.A. An ASC shall be certified by CMS to participate in the Medicare program as an ASC and be licensed by the Colorado Department of Public Health and Environment as an ASC.

8.570.3 COVERED SERVICES AND LIMITATIONS

- 8.570.3.A. Covered services are those surgical and other medical procedures that:
 - 1. Are ASC procedures that are grouped into categories corresponding to the CMS defined groups.
 - 2. Are commonly performed on an inpatient basis in hospitals, but may be safely performed in an ASC.
 - 3. Are limited to those requiring a dedicated operating room (or suite), and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room.
- 8.570.3.B. Covered surgical procedures are limited to those that do not generally exceed:
 - 1. A total of 4 hours recovery or convalescent time.

8.570.3.C. If the covered surgical procedures require anesthesia, the anesthesia must be:

1. Local or regional anesthesia; or
2. General anesthesia.

8.570.4. DENTAL PROCEDURES

1. Qualifying clients may receive covered and medically necessary dental services in an ASC when those services cannot be delivered safely and effectively in a private office.

8.570.5 NON-COVERED SERVICES

8.570.5.A Non-covered services are those services that:

1. Are not commonly performed in an ASC;
2. May safely be performed in a physician's office;
3. Generally result in extensive blood loss;
4. Require major or prolonged invasion of body cavities;
5. Directly involve major blood vessels;
6. Are generally emergency or life-threatening in nature;
7. Pose a significant safety risk to clients or are expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay) when furnished in an ASC.
8. Are not listed in the annual ASC billing manual.

8.570.6. CLIENT ELIGIBILITY

Eligible Clients include any Client enrolled in Colorado Medicaid for whom a covered ASC service is a medical necessity as defined at 10 CCR 2505-10 Section 8.076.1.8.

8.570.7. PRIOR AUTHORIZATION

The physician performing the surgery shall be responsible for obtaining all necessary Prior Authorizations for those procedures requiring pre-procedure approval by the Department.

8.570.8 REIMBURSEMENT

8.570.8.A For payment purposes, ASC surgical procedures are placed into groupers. The Health Care Procedural Coding System (HCPCS) is used to identify surgical services.

8.570.8.B Reimbursement for approved surgical procedures shall be allowed only for the primary or most complex procedure. No reimbursement is allowed for multiple or subsequent procedures. No reimbursement shall be allowed for services not included on the Department approved list for covered services. Approved surgical procedures identified in the ASC groupers shall be reimbursed a facility fee at the lower of the following:

1. Submitted charges; or

2. Department approved list for covered services.

8.570.9 ALLOWABLE COSTS

8.570.9.A The services payable under this rule are facility services furnished to clients in connection with covered surgical procedures specified in Section 8.570.3.

1. Services and items reimbursed as part of the facility fee include, at a minimum, the following:
 - a. Use of the facilities where the surgical procedures are performed.
 - b. Nursing, technician, and related services.
 - c. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures.
 - d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.
 - e. Administrative, record keeping and housekeeping items and services.
 - f. Materials for anesthesia.
 - g. Intra-ocular lenses (IOLs).
 - h. Supervision of the services of an anesthetist by the operating surgeon.
2. Services and items that are not reimbursed as part of the facility fee, but that may be reimbursed separately include the following:
 - a. Physician services.
 - b. Anesthetist services.
 - c. Laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure.)
 - d. Prosthetic devices (except IOLs).
 - e. Ambulance services.
 - f. Leg, arm, back and neck braces.
 - g. Artificial limbs.
 - h. Durable medical equipment for use in the client's home.

8.571 CLINIC SERVICES - AMBULATORY SURGERY CENTER, PHYSICIAN PRIOR AUTHORIZATION

The physician performing the surgery shall be responsible for obtaining all necessary Prior Authorizations for those procedures requiring pre-procedure approval by the Department.

8.580 OXYGEN AND OXYGEN EQUIPMENT

8.580.1 OXYGEN AND OXYGEN EQUIPMENT PROVIDED IN CLIENT HOMES

- 8.580.1.A. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician, are a Medicaid benefit if provided in the client's home, or place of residence, not to include intermediary or skilled nursing facilities.
- 8.580.1.B. The oxygen provider shall directly bill the Department for medically necessary liquid or gaseous oxygen equipment and supplies provided in a client's home or place of residence, not to include intermediary or skilled nursing facilities. Reimbursement shall be the lower of the provider's billed charge or the Department's fee schedule.

8.580.2 OXYGEN, AND OXYGEN EQUIPMENT, PROVIDED TO HOSPITAL CLIENTS

- 8.580.2.A. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician for any form of oxygen for a client in an inpatient hospital setting are a benefit.
- 8.580.2.B. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician for any form of oxygen for a client in an inpatient hospital setting shall be provided by the hospital and is included in the Medicaid payment for inpatient hospital services.

8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS

- 8.580.3.A. Oxygen, oxygen equipment and/or supplies when medically necessary and prescribed by the physician for clients residing in an intermediary or skilled nursing facility are a benefit.
- 8.580.3.B. Oxygen equipment and/or supplies for clients residing in a nursing facility being reimbursed a per diem amount, shall be provided by the nursing facility, except when the facility orders oxygen equipment and/or supplies specifically for the unique needs of an individual client. In such cases, the oxygen equipment and/or supply provider shall bill the Department directly.
- 8.580.3.C. Oxygen concentrators for use by clients residing in a nursing facility being reimbursed a per diem rate shall be provided in one of the following ways:
1. Oxygen concentrators purchased by the facilities shall be included in the facility cost report and reimbursed through the per diem. All necessary oxygen-related supplies shall be provided by the facility in accordance with 10 C.C.R. 2505-10, Section 8.441.5.K.
 2. Clients residing in facilities that do not purchase oxygen concentrators shall obtain equipment and supplies from an authorized Medicaid oxygen provider. The oxygen provider shall provide equipment, oxygen and supplies for use by a specific client, as ordered by the client's physician, and shall bill on the state approved form.
- 8.580.3.D. The oxygen provider shall bill the Department directly for medically necessary liquid or gaseous oxygen provided to clients residing in intermediary or skilled nursing facilities that are reimbursed a per diem amount.
- 8.580.3.E. The oxygen provider shall bill based on the information provided by the nursing facility. Claims shall be coded appropriately as defined by the Department. Reimbursement shall be the lower of the provider's billed charges or the Department's fee schedule.

8.580.4 DME Oxygen Benefit Coverage Standard Incorporation by Reference

8.580.4.A Standard Incorporated by Reference

All eligible providers of DME oxygen enrolled in the Colorado Medicaid program shall be in compliance with the Colorado Medicaid DME Oxygen Benefit Coverage Standard (approved September 1, 2011), which is hereby incorporated by reference. The incorporation of the DME Oxygen Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.585 OXYGEN, OXYGEN EQUIPMENT, AND SUPPLIES

Medically necessary oxygen, oxygen equipment, and supplies are a benefit of the Colorado Medicaid Program. Medical necessity shall be provided in a manner approved by the Department, and shall be maintained in the provider's files for a minimum of six (6) years. The Department reserves the right to request copies of documentation of medical necessity.

- .01 With the exception of liquid or gaseous oxygen provided in a nursing facility, and the supplies and equipment necessary to administer each, medical equipment and/or supplies for Medicaid clients residing in a nursing facility, or group home receiving daily Medicaid reimbursement, must be provided by the facility. Costs of equipment and/or supplies unrelated to the use of gaseous or liquid oxygen are included in the facility's cost report and reimbursed through the Medicaid per diem.
- .02 Any form of oxygen for use by clients in an inpatient hospital setting must be provided by the hospital and is included in the Medicaid payment. Oxygen concentrators for use by clients residing in a nursing facility, or group home receiving daily Medicaid reimbursement, may be provided in one of two ways.
 - A. Nursing facilities or group homes committed to a program of purchasing concentrators for use by their Medicaid residents may bill a monthly fee to the Department using the Nursing Home Claim Form, in accordance with 8.465. All necessary oxygen -related disposable supplies shall also be provided by the facility.
 - B. Residents of facilities which do not wish to purchase concentrators for patient use shall obtain needed equipment from an authorized Medicaid oxygen supplier. The oxygen supplier shall bill a monthly fee using the Supply Claim. Reimbursement will be the lower of billed charges or the Department's fee schedule.
- .03 Liquid and gaseous oxygen, as well as equipment and supplies provided by the medical equipment supplier for administration in a nursing facility or group home, shall be billed directly to the Department's fiscal agent by a Medicaid supply provider, in accordance with Department policy.
- .04 Medical suppliers providing oxygen to Medicaid clients shall provide equipment, supplies and oxygen for use by a specific client, based upon the physician's prescription.

- .05 In order to assure accurate and appropriate billing by the medical supplier, the nursing facility or group home shall be responsible for providing the following information to the medical supplier within 20 days following the date the supplier delivers the item to be billed. The required information shall be in the form of a certification statement and shall contain the following, as a minimum:
- A. the name and state ID number for all Medicaid clients provided liquid or gaseous oxygen, or the equipment/supplies necessary for administration by the medical supplier.
 - B. an indicator of Medicare Part A or B, or other third party resources.
 - C. the name and state ID number for all Medicaid clients utilizing an oxygen concentrator being rented from the oxygen supplier. This applies only to patients in those facilities which choose not to commit to the purchase of concentrators.
 - D. certification guaranteeing that equipment, supplies, and oxygen were used only by the patient for which they were supplied; or in the case of centralized oxygen systems, each client's oxygen usage, expressed in liters.
- .06 The medical supplier shall bill the Medicaid program based upon the above information provided by the nursing facility, using the appropriate HCPCS coding. Reimbursement shall be made in accordance with the Department's fee schedule or the provider's usual and customary charges, whichever is lower.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.590.1 DEFINITIONS

- A. Abuse, for the purposes of rule 8.590, means the intentional destruction of or damage to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies that results in the need for repair or replacement.
- B. Billing Manual, for the purposes of rule 8.590, means a reference document that assists providers with appropriately billing claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.
- C. Cochlear Implant or cochlear prosthesis means an electrode or electrodes surgically implanted in the cochlea which are attached to an induction coil buried under the skin near the ear, and the associated unit which is worn on the body.
- D. Complex Rehabilitation Technology means individually configured manual Wheelchair systems, power Wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designated options and accessories, which qualify as Durable Medical Equipment that:
 - 1. Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living, including employment, identified as medically necessary to promote mobility in the home and community or prevent hospitalization or institutionalization of the member;
 - 2. Are primarily used to serve a medical purpose and generally not useful in the absence of disability, illness or injury; and

3. Require certain services provided by a qualified Complex Rehabilitation Technology Supplier to ensure appropriate design, configuration, and use of such items, including patient evaluation or assessment of the client by a Qualified Health Care Professional, and that are consistent with the member's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.
- E. Complex Rehabilitation Technology Professional means an individual who is certified by the Rehabilitation Engineering and Assistive Technology Society of North America or other nationally recognized accrediting organizations as an assistive technology professional.
- F. Complex Rehabilitation Technology Supplier means a provider who meets all the requirements of Section 8.590.5.D.
- G. Disposable Medical Supplies (Supplies) means health care related items that are consumable, disposable, or cannot withstand repeated use by more than one individual. Supplies are required to address an individual medical disability, illness or injury.
- H. Durable Medical Equipment (DME) means items, including Prosthetics and Orthotics, that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.
- I. Facilitative Device means DME with a retail price equal to or greater than one hundred dollars that is exclusively designed and manufactured for a member with disabilities to improve, maintain or restore self-sufficiency or quality of life through facilitative technology. Facilitative Devices do not include Wheelchairs.
- J. Financial Relationship means any ownership interest, investment interest or compensation arrangement between a provider, or their officers, directors, employees or Immediate Family Members of the provider, and the entity. An ownership or investment interest may be reflected in equity, debt, or other instruments and includes, but is not limited to, mortgages, deeds of trust, notes or other obligations secured by either entity.
- K. Hearing Aid means a wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories thereto, including ear molds but excluding batteries and cords.
- L. Immediate Family Member means any spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, sibling or stepsibling, in-laws, grandparents and grandchildren.
- M. Medical Necessity, for the purposes of Section 8.590, means the definition as described at 10 CCR 2505-10, Section 8.076.1.8.
- N. Misuse means failure to maintain or the intentional utilization of DME and Supplies in a manner not prescribed, recommended or appropriate that results in the need for repairs or replacement. Misuse also means DME and Supplies used by someone other than the member for whom it was prescribed.
- O. Prosthetic or Orthotic Device means replacement, corrective or supportive devices that artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

- P. Qualified Health Care Professional means a licensed physical therapist, a licensed occupational therapist, or other licensed health care professional who performs specialty evaluations within his/her scope of practice and who has no Financial Relationship with a Complex Rehabilitation Technology Supplier.
- Q. Related Owner means an individual with 5% or more ownership interest in a business and one entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business.
- R. Related Party means a provider who is associated or affiliated with, or has control of, or is controlled by the organization furnishing the DME and Supplies. An owner related individual shall be considered an individual who is a member of an owner's Immediate Family.
- S. Speech Generating Device (SGD) means a device that provides multiple methods of message formulation and is used to establish, develop or maintain the ability to communicate functional needs. These devices are electronic and computer based and can generate synthesized (computer-generated) or digitized (natural human) speech output for expressive communication.
- T. Wheelchair means any wheelchair or scooter that is motor driven or manually operated for the purposes of mobility assistance, purchased by the Department or donated to the member.
- U. Wrongful Disposition means the mismanagement of DME and Supplies by a member by selling or giving away the item reimbursed by the Department.

8.590.2 BENEFITS

8.590.2.A. All covered DME and Supplies shall, at a minimum, be:

1. A Medical Necessity; and
2. Prescribed by a physician and, when applicable, recommended by an appropriately licensed practitioner.

8.590.2.B. DME and Supplies for Members Residing in Facilities

1. DME and Supplies for members residing in a hospital, nursing facility or other facility, are provided by those facilities and reimbursed as part of the per diem rate. DME and Supplies shall not be separately billed, except under the following circumstances:
 - a. The member is within fourteen days of discharge, and
 - b. Prior authorization or training are needed to assist the member with equipment usage, and
 - c. The equipment is needed immediately upon discharge from the facility.
2. Repairs and modifications to member owned DME, not required as part of the per diem reimbursement, shall be provided to members residing in a hospital, nursing facility or other facility receiving per diem Medicaid reimbursement.
3. Prosthetic or Orthotic Devices may be provided to members residing in a hospital, nursing facility or other facility receiving per diem Medicaid reimbursement if Prosthetic or Orthotic benefits are not included in the facility's per diem rate.

- 8.590.2.C. DME and Supplies shall not be duplicative or serve the same purpose as items already utilized by the member unless it is medically required for emergency or backup support. Backup equipment shall be limited to one.
- 8.590.2.D. All DME and Supplies reimbursed for by the Department shall become the property of the member unless the member and provider are notified otherwise by the Department at the time of purchase.
- 8.590.2.E. Rental equipment shall be provided if the Department determines it to be cost effective and Medically Necessary.
- 8.590.2.F. Supplies shall be for a specific purpose, not incidental or general purpose usage.
- 8.590.2.G. The following DME and Supplies categories are benefits for members regardless of age, and include but are not limited to:
1. Ambulation devices and accessories including but not limited to canes, crutches or walkers.
 2. Bath and bedroom safety equipment.
 3. Bath and bedroom equipment and accessories including, but not limited to, specialized beds and mattress overlays.
 4. Manual or power Wheelchairs and accessories.
 5. Diabetic monitoring equipment and related disposable supplies.
 6. Elastic supports/stockings.
 7. Blood pressure, apnea, blood oxygen, pacemaker and uterine monitoring equipment and supplies.
 8. Oxygen and oxygen equipment in the member's home, a nursing facility or other institution. The institutional oxygen benefit is fully described in 10 C.C.R. 2505-10, Sections 8.580, and 8.585.
 9. Transcutaneous and/or neuromuscular electrical nerve stimulators (TENS/NMES) and related supplies.
 10. Trapeze, traction and fracture frames.
 11. Lymphedema pumps and compressors.
 12. Specialized use rehabilitation equipment.
 13. Oral and enteral formulas and supplies.
 14. Parenteral equipment and supplies.
 15. Environmental controls for a member living unattended if the controls are needed to assure medical safety.
 16. Facilitative Devices.

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- a. Telephone communication devices for the hearing impaired and other facilitative listening devices, except hearing aids, and Cochlear Implants.
 - b. Computer equipment and reading devices with voice input or output, optical scanners, talking software, Braille printers and other devices that provide access to text.
 - c. Computer equipment with voice output, artificial larynges, voice amplification devices and other alternative and augmentative communication devices.
 - d. Voice recognition computer equipment software and hardware and other forms of computers for persons with disabilities.
 - e. Any other device that enables a person with a disability to communicate, see, hear or maneuver including artificial limbs and orthopedic footwear.
17. Complex Rehabilitation Technology.
- 8.590.2.H. The following DME are benefits to members under the age of 21:
- 1. Hearing aids and accessories.
 - 2. Phonic ear.
 - 3. Therapy balls for use in physical or occupational therapy treatment.
 - 4. Selective therapeutic toys.
 - 5. Computers and computer software when utilization is intended to meet medical rather than educational needs.
 - 6. Vision correction unrelated to eye surgery.
- 8.590.2.I. The following Prosthetic or Orthotic Devices are benefits for members regardless of age:
- 1. Artificial limbs.
 - 2. Facial Prosthetics.
 - 3. Ankle-foot/knee-ankle-foot orthotics.
 - 4. Recumbent ankle positioning splints.
 - 5. Thoracic-lumbar-sacral orthoses.
 - 6. Lumbar-sacral orthoses.
 - 7. Rigid and semi-rigid braces.
 - 8. Therapeutic shoes.
 - 9. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements.
 - 10. Specialized eating utensils and other medically necessary activities of daily living aids.
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11. Augmentative communication devices and communication boards.
- 8.590.2.J. Repairs and replacement parts are covered under the following conditions:
1. The item was purchased by Medicaid; or
 2. The item is owned by the member, member's family or guardian; and
 3. The item is used exclusively by the member; and
 4. The item's need for repair was not caused by member Misuse or Abuse; and
 5. The item is no longer under the manufacturer warranty.
- 8.590.2.K. The minimum replacement timeline for a Speech Generating Device is five years.
1. Stolen devices may be replaced within the five-year timeline; however, the client is limited to one-time replacement due to theft, and a police report must be provided for verification of the incident.
 2. Replacement will not be granted within the five-year timeline for devices that are damaged, lost, misused, abused or neglected.
- 8.590.2.L. Repairs, replacement, and maintenance shall be:
1. Based on the manufacturer's recommendations, and
 2. Performed by a qualified rehabilitation professional, and
 3. Allowed on the member's primary equipment or one piece of backup equipment.
 4. Multiple backup equipment will not be repaired, replaced or maintained.
- 8.590.2.M. If repairs are frequent and repair costs approach the purchase price of new equipment, the provider shall make a request for the purchase of new equipment. The prior authorization request shall include supporting documentation explaining the need for the replacement equipment and the cost estimates for repairs on both the old equipment and the new equipment purchase.
- 8.590.2.N. Supplies are a covered benefit when related to the following:
1. Surgical, wound or burn care.
 2. Syringes or needles.
 3. Bowel or bladder care.
 4. Incontinence.
 5. Antiseptics or solutions.
 6. Gastric feeding sets and supplies.
 7. Tracheostomy and endotracheal care supplies.
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8. Diabetic monitoring.
- 8.590.2.O. Quantities of Supplies shall not exceed one month's supply unless they are only available in larger quantities as packaged by the manufacturer.
- 8.590.2.P. Medicaid members for whom Wheelchairs, Wheelchair component parts and other specialized equipment were authorized and ordered prior to enrollment in a Managed Care Organization, but delivered after the Managed Care Organization enrollment shall be the responsibility of the Department. All other DME and Supplies for members enrolled in a Managed Care Organization shall be the responsibility of the Managed Care Organization.
- 8.590.2.Q. Items, for the purposes of Rule 8.590, that are used for the following are not a benefit to a member of any age:
 1. Routine personal hygiene.
 2. Education.
 3. Exercise.
 4. Participation in sports.
 5. Cosmetic purposes.
- 8.590.2.R. For members age 21 and over, the following items are not a benefit:
 1. Hearing aids and accessories.
 2. Phonic ears.
 3. Therapeutic toys.
 4. Vision correction unrelated to eye surgery.
- 8.590.2.S. Rental Policy.
 1. The Department may set a financial cap on certain rental items. The monetary price for those items shall be determined by the Department and noted in the fee schedule. The provider is responsible for all maintenance and repairs as described at 8.590.4.N-P, until the cap is reached.
 2. Upon reaching the capped amount, the equipment shall be considered purchased and shall become the property of the member. The provider shall give the member or caregiver all applicable information regarding the equipment. The equipment shall not be under warranty after the rental period ends.
 3. The rental period may be interrupted, for a maximum of sixty consecutive days.
 - a. If the rental period is interrupted for a period greater than sixty consecutive days, the rental period must begin again. The interruption must be justified, documented by a physician, and maintained by the provider as described at 10 CCR 2505-10, Section 8.590.4.E.
 4. If the member changes providers, the current rental cap remains in force.

8.590.3 PRIOR AUTHORIZATION

8.590.3.A. Selected DME and Supplies require prior authorization approval. All items requiring prior authorization are listed in the Billing Manual.

8.590.3.B. Prior authorization shall not be required for Medicare covered crossover claims.

8.590.3.C. Prior authorization shall be required for members who have other primary insurance besides Medicare.

8.590.3.D. Prior authorization requests shall, include the following information:

1. A full description of the item(s).
2. The requested number of items.
3. A full description of all attachments, accessories and/or modifications needed to the basic item(s).
4. The effective date and estimated length of time the item(s) will be needed.
5. The medical diagnosis, prognosis for improvement or deterioration, previous and description of current treatments and any other clinical information necessary to establish Medical Necessity for the member.
6. Descriptions of any specific physical limitations, or current functional needs, the member may have that are relevant to the prior authorization consideration.
7. The member's prescribing physician's, primary care physician's and provider's name and identification numbers.
8. The serial numbers for all Wheelchair repairs.
9. The prescribing physician's signature. The prescribing physician can either sign the authorization or attach a written prescription or letter of Medical Necessity to the authorization.

8.590.3.E. Prior authorization requests for DME must meet the prior authorization criteria at 10 CCR 2505-10, Section 8.590.3.D, and the applicable DME or Supply specific criteria below:

1. Prior authorization requests for Speech Generating Devices shall include an communication assessment, made by a licensed speech-language pathologist, which provides documentation of:
 - a. The member's communication limitations and skills; and
 - b. A history of communication-related therapies; and
 - c. A description of any trials required for the recommended device, including how each device trial met or failed to meet the member's functional communication needs; and
 - d. Evidence that alternative, natural communication methods have been ineffective; and

- e. The member's ability to operate the device both cognitively and physically; and
- f. Expected improvement in the member's independence or personal safety, ability to communicate medical and basic needs, provide feedback on treatment or therapy programs, and prevent secondary impairments.

8.590.3.F. Diagnostic and clinical information shall be completed prior to the physician's signature. The provider shall not complete or add information after the physician has signed the document.

8.590.3.G. Requests for prior authorization shall be submitted in a timely fashion. Requests for prior authorization submitted with a begin date in excess of three months prior to the date of submission shall include additional, updated documentation indicating the continued Medical Necessity of the request. Retroactive approval beyond three months without such documentation shall be considered only in cases of member retroactive program eligibility.

8.590.3.H. Approval of a prior authorization does not guarantee payment or constitute a waiver of any claims processing requirements including, but not limited to, eligibility and timely filing.

8.590.4 PROVIDER RESPONSIBILITIES

8.590.4.A. Providers shall issue express warranties for Wheelchairs and Facilitative Devices and shall assure that any refund resulting from the return of a Wheelchair or other Facilitative Device is returned to the Department in compliance with Sections 6-1-401 to 6-1-412, C.R.S. (2016) and Sections 6-1-501 to 6-1-511, C.R.S. (2016). Sections 6-1-401 to 6-1-412 and 6-1-501 to 6-1-511, C.R.S. (2016) are hereby incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S. (2016), the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado.

8.590.4.B. The Provider shall implement a system that supports member autonomy and describes how equipment will be serviced and maintained, routine follow-up and response procedures to prevent any interruption of services to the members. This system shall include provisions describing how service and repairs may occur at the member's location when appropriate.

- 1. Providers shall furnish the member with written information at the time of sale on how to access service and repair.

8.590.4.C. The Provider shall implement and maintain a process for honoring all warranties expressed and implied under applicable State laws.

8.590.4.D. Providers of custom Wheelchairs, seating products and any other DME shall be able to appropriately assess and provide adequate repairs, adjustment and service by qualified rehabilitation professionals for all products they distribute.

8.590.4.E. Providers shall maintain the following for all items provided to a member:

- 1. Physician prescriptions.
- 2. Approved prior authorization requests.
- 3. Additional documentation received from physicians or other licensed practitioners.
- 4. Documentation that the member or caregiver have been provided with the following:

- a. Manufacturer's instructions.
 - b. Warranty information.
 - c. Registration documents.
 - d. Service manual.
 - e. Operating guides.
 5. Documentation on all reimbursed equipment, which shall include:
 - a. Manufacturer's name and address.
 - b. Date acquired.
 - c. Acquisition cost.
 - d. Model number.
 - e. Serial number.
 - f. Accessories, attachments or special features included in the item.
 6. Providers shall verify that equipment requiring repairs belongs to the presenting member.
 7. Providers shall retain all documentation for a period of six years.
 8. Providers shall provide a copy of all documentation to a member or his/her representative, if requested.
- 8.590.4.F. Providers shall be responsible for delivery of and instructing the member on the proper use of the ordered/authorized equipment or supplies appropriate for the stated purpose consistent with the requirements, goals and desired outcomes at the time of the prescription and delivery.
- 8.590.4.G. The provider shall be responsible for member evaluation, wheelchair measurements and fittings, member education, adjustments, modifications and delivery set-up installation of equipment in the home. If modifications require the provider to fabricate customized equipment or orthotics to meet member needs, the provider shall justify the necessity and the cost of additional materials of the modifications. Modifications shall not alter the integrity, safety or warranty of the equipment.
- 8.590.4.H. The provider shall pick-up inappropriate or incorrect items within five business days of being notified. The provider shall not bill the Department for items known to be inappropriate or incorrect and awaiting pick-up. The provider shall submit a credit adjustment to the Department within twenty business days following the pick-up date if a claim was submitted prior to notification an item was inappropriate or incorrect.
- 8.590.4.I. Providers shall confirm continued need for disposable supplies with the member or caretaker prior to supply shipment.
- 8.590.4.J. All purchased equipment shall be new at the time of delivery to the member unless an agreement was reached in advance with the member and Department.

- 8.590.4.K. Providers shall provide DME and Supplies, repairs and all other services in the same manner they provide these services to non-Medicaid clients.
- 8.590.4.L. Providers shall ensure the equipment provided will be warranted in accordance with the manufacturer's warranty. The provider shall not bill Medicaid or the member for equipment, parts, repairs, or other services covered by the warranty.
- 8.590.4.M. The following requirements shall apply to warranted items:
1. The provider shall provide adequate repairs, adjustments and services by appropriately trained technicians for all products they distribute.
 2. The provider shall complete services or repairs in a timely manner and advise the member on the estimated completion time.
 3. The provider shall arrange for appropriate alternative, like equipment in the absence of member owned backup equipment. The provider shall provide the alternative equipment at no cost. If the backup equipment is not available as loan equipment, the provider shall arrange for a temporary equipment rental through the Department.
 4. The provider shall exclude from warranty provisions, replacement or repairs to equipment that are no longer able to meet member needs due to changes in anatomical and/or medical condition that occurred after purchase.
 5. The provider may refuse warranty services on items for which there have been documented patterns of specific member Misuse or Abuse. The provider shall notify the Department in all documented cases of Misuse or Abuse within ten business days of learning of the incident of Misuse or Abuse.
- 8.590.4.N. Previously used or donated DME may be provided to the member if agreed upon by the member and the Department. Approval will be coordinated by the Utilization Management Vendor.
- 8.590.4.O. The Provider shall assure that used or donated items provided meet the following conditions:
1. The item is fully serviced and reconditioned.
 2. The item is functionally sound and in good operating condition.
 3. The item will be repaired and have parts replaced in a manner equivalent to an item that is new. The item will have parts available for future repairs in a manner equivalent to the manufacturer's warranty on a like item which is new.
 4. The provider will make all adjustments and modifications needed by the member during the first year of use, except for changes and adjustments required due to growth or other anatomical changes or for repairs not covered by the manufacturer's warranty on a like new item.
- 8.590.4.P. The provider shall receive and perform service and repairs in the same manner they provide services for non-Medicaid clients for rental equipment.
- 8.590.4.Q. The provider shall assure the following for rental equipment:
1. Appropriate service to the item.

2. Complete services or repairs in a timely manner with an estimate of the approximate time required.
3. Appropriate alternative equipment during repairs.
4. Provision and replacement of all expendable items, including but not limited to hoses, fuses, and batteries.

8.590.5 PROVIDER REQUIREMENTS

8.590.5.A. Providers are required to be enrolled with the Colorado Medical Assistance Program and maintain a certification for Medicare accreditation through a Medicare approved accreditation agency.

8.590.5.B. Providers must have one or more physical location(s), within the State of Colorado, or within fifty (50) miles of any Colorado border and must also have:

1. A street address; and
2. A local business telephone number; and
3. An inventory; and
4. Sufficient staff to service or repair products.

8.590.5.C. Providers who do not meet the requirements of 8.590.5.A may apply to become a Medicaid provider if the DME or Supplies are medically necessary and cannot otherwise be purchased from a provider who meets the requirements of 8.590.5.A.

1. Applications from providers who do not meet the requirements of 8.590.5.A must be submitted to the DME Program Coordinator for approval.
2. Applications submitted pursuant to this section will be reviewed for approval on a case-by-case basis for those specialty items only.

8.590.5.D. To qualify as a Complex Rehabilitation Technology Supplier, a provider must meet the following requirements:

1. Be accredited by a recognized accrediting organization as a supplier of Complex Rehabilitation Technology;
2. Meet the supplier and quality standards established for DME suppliers under the Medicare or Medical Assistance Program;
3. Employ at least one Complex Rehabilitation Technology Professional at each physical location to:
 - a. Analyze the needs and capacities of a member for a Complex Rehabilitation Technology item in consultation with the evaluating clinical professionals;
 - b. Assess and determine the appropriate Complex Rehabilitation Technology for a member, with such involvement to include seeing the member either in person or by any other real-time means within a reasonable time frame during the determination process; and

- c. Provide the member with technology-related training in the proper use and maintenance of the selected Complex Rehabilitation Technology items.
4. Maintain a reasonable supply of parts, adequate physical facilities, qualified and adequate service or repair technicians to provide members with prompt service and repair of all Complex Rehabilitation Technology it sells or supplies.

8.590.6 MEMBER RESPONSIBILITIES

- 8.590.6.A. Members or member caregivers shall be responsible for the prudent care and use of DME and Supplies. Repairs, servicing or replacement of items are not a benefit if there is documented evidence of member Misuse, Abuse or Wrongful Disposition.
- 8.590.6.B. Members shall be responsible for the cost of any additional items or enhancements to equipment not deemed Medically Necessary. The member shall sign an agreement with the provider that states:
1. The cost of the items.
 2. That the member was not coerced into purchasing the items.
 3. That the member is fully responsible for the cost, servicing and repairs to the items after the warranty period is completed.
- 8.590.6.C. The member shall contact the point of purchase for service and repairs to covered items under warranty. Members may contact a participating provider of their choice for service and repairs to covered items not under warranty or for an item under warranty if the original point of purchase is no longer a participating provider.
- 8.590.6.D. The member shall become the owner of any equipment purchased by the Department and remains subject to Medicaid DME rules unless otherwise notified by the Department at the time of purchase.
- 8.590.6.E. The member shall be responsible for obtaining a police report for items being replaced due to theft, fire damage or accident. The police report shall be attached to the prior authorization requesting replacement of the item.
- 8.590.6.F. The member shall be responsible for reporting to the manufacturer, dealer or alternative warranty service provider instances where a Wheelchair or Facilitative Device does not conform to the applicable express warranty.
- 8.590.6.G. The member or caregiver shall be responsible for routine maintenance on all equipment purchased or rented by the Department. Routine maintenance is the servicing described in the manufacturer's operating manual as being performed by the user to properly maintain the equipment. Non-performance of routine maintenance shall be considered Misuse. Routine maintenance includes, but is not limited to:
1. Cleaning and lubricating moving parts.
 2. Adding water to batteries.
 3. Checking tire pressure.
 4. Other prescribed Manufacturer procedures.

8.590.6.H. The member utilizing rental equipment shall be responsible for notifying the provider of any change of address. The member shall be responsible for any rental fee accrued during the time the equipment's location is unknown to the provider.

8.590.6.I. The member shall not remove rental equipment from Colorado.

8.590.7 REIMBURSEMENT

8.590.7.A. A provider, as defined at Section 25.5-4-414, C.R.S., is prohibited from making a referral to an entity providing DME and Supplies under the Medical Assistance Program if the provider or an Immediate Family member of the provider has a Financial Relationship with the entity unless the Financial Relationship meets the requirements of an exception to the prohibitions established by 42 U.S.C. Section 1395nn (2017), as amended or any regulations promulgated thereunder, as amended. 42 U.S.C. §1395nn (2017) is hereby incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado.

8.590.7.B. If a provider refers a Medicaid member for DME and Supplies services in violation of Section 25.5-4-414, C.R.S., or this rule, then the Department may

1. Deny any claims for payment from the provider;
2. Require the provider to refund payments for services or items;
3. Refer the matter to the appropriate agency for investigation for fraud; or
4. Terminate the provider's Colorado Medicaid provider participation agreement.

8.590.7.C. Invoices received from Related Owners or Related Parties shall not be accepted. Only invoices received from unrelated manufacturers or wholesale distributors shall be recognized as allowable invoices.

8.590.7.D. The provider shall not bill the Department for authorized accessory items included by the manufacturer as part of a standard package for an item.

8.590.7.E. The provider shall credit the cost of any accessory or part removed from a standard package to the Department.

8.590.7.F. Members and providers may negotiate in good faith a trade-in amount for DME items no longer suitable for a member because of growth, development or a change in anatomical and or medical condition. Such trade-in allowances shall be used to reduce the cost incurred by the Department for a replacement item.

8.590.7.G. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacturer; wherever the item was returned, and the Department.

8.590.7.H. Reimbursement for allowable modifications, service, and repairs on DME is as follows:

1. Labor for modifications, service, and repairs on DME shall be reimbursed at the lesser of submitted charges or the rate specified on the Department's fee schedule.

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2. Parts that are listed on the Department's fee schedule, with a HCPCS code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.
 3. Manually priced parts are reimbursed according to the same methodology used for purchased equipment, as described in 8.590.7.K.
 4. The provider shall not be reimbursed for labor or parts in excess of unit limitations.
 5. Reimbursement for a modification that requires the original equipment provider to supply a part from their own inventory or stock is contingent upon the provider submitting supporting documentation that demonstrates the need and actual cost of the parts to be used in the modification.
- 8.590.7.I. Reimbursement for used equipment shall include:
1. A written, signed and dated agreement from the member accepting the equipment.
 2. Billing the Department, the lesser of 60% of the maximum allowable reimbursement indicated in the most recent Medicaid Bulletin or 60% of the provider's usual submitted charges.
 - a. For used equipment subject to the upper payment limit provisions of section 1903(i)(27) of the Social Security Act, the maximum allowable reimbursement will be the lower of 100% of the applicable Medicare used reimbursement rate effective as of January 1 and posted by July 1 of each year, or the provider's submitted charges.
- 8.590.7.J. Reimbursement for purchased or rented equipment shall include, but is not limited to:
1. All elements of the manufacturer's warranties or express warranties.
 2. All adjustments and modification needed by the member to make the item useful and functional.
 3. If item is delivered, set-up and installation of equipment in an appropriate room in the home, if applicable.
 4. Training and instruction to the member or caregiver in the safe, sanitary, effective and appropriate use of the item and necessary servicing and maintenance to be done by the member or caregiver.
 5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides.
- 8.590.7.K. Reimbursement rate for a purchased item shall be as follows:
1. Fee schedule items, with a HCPCS code, that have a maximum allowable reimbursement rate, shall be reimbursed at the lesser of submitted charges or the Department fee schedule rate.
 2. Manually priced items that do not have an assigned fee schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less a percentage set forth below:

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- a. July 1, 2017 to June 30, 2018, the percentage is 18.33.
 - b. Pending federal approval, effective July 1, 2018, the percentage is 17.51.
 - 3. Manually priced items that do not have an assigned fee schedule rate and have no MSRP shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus a percentage set forth below:
 - c. July 1, 2017 to June 30, 2018, the percentage is 19.50.
 - d. Pending federal approval, effective July 1, 2018, the percentage is 20.70.
 - 8.590.7.L. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Billing Manual.
 - 8.590.7.M. Reimbursement for members eligible for both Medicare and Medicaid shall be made in the following manner:
 - 1. The provider shall bill Medicare first unless otherwise authorized by the Department.
 - 2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments.
 - 3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions:
 - a. A copy of the Explanation of Medicare Benefits shall be maintained in the provider's files when billing electronically or attached to the claim if it is billed manually; or
 - b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error.
 - 8.590.7.N. Face-to-Face Encounters
 - 1. For DME specified in the Billing Manual, a face-to-face encounter must be performed related to the primary reason a member requires the DME.
 - 2. The face-to-face encounter must occur no more than six months before the DME is first provided to a member.
 - 3. The face-to-face encounter must be conducted by one of the following practitioners:
 - a. The physician responsible for prescribing the DME;
 - b. A nurse practitioner or clinical nurse specialist, working in collaboration with the prescribing physician; or
 - c. A physician assistant under the supervision of the prescribing physician.
 - 4. A practitioner may conduct a face-to-face encounter via telehealth or telemedicine if those services are covered by the Medical Assistance Program.
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5. If a non-physician practitioner performs a face-to-face encounter they must communicate the clinical findings of the face-to-face encounter to the physician responsible for prescribing the related DME. Those clinical findings must be incorporated into a written or electronic document included in the member's medical record.
 6. A physician who prescribes DME requiring face-to-face encounters must document the following:
 - a. The face-to-face encounter was related to the primary reason the member required the prescribed DME;
 - b. The practitioner who performed the face-to-face encounter;
 - c. The date of the face-to-face encounter; and
 - d. The face-to-face encounter occurred within the required timeframe.
 7. Compliance with this section is required as a condition of payment for DME requiring face-to-face encounters.
- 8.590.7.O. Reimbursement for Complex Rehabilitation Technology provided to members is subject to the following conditions:
1. The billing provider is a Complex Rehabilitation Technology Supplier;
 2. The member has been evaluated or assessed, for selected Complex Rehabilitation Technology identified in the Billing Manual, by:
 - a. A Qualified Health Care Professional; and
 - b. A Complex Rehabilitation Technology Professional employed by the billing provider.
 3. The Complex Rehabilitation Technology is provided in compliance with all applicable federal and state laws, rules, and regulations, including those rules governing the Medical Assistance Program.
- 8.590.7.P. Reimbursement for Speech Generating Devices (SGD), accessories, and software provided to members is subject to the following conditions:
1. The member has a medical condition resulting in a severe expressive communication impairment; and
 2. The SGD, accessories and software is used primarily as a communication device; and
 3. The SGD, accessories or software are recommended by a Speech Language Pathologist after a communication assessment as described at 10 CCR 2505-10, Section 8.590.3.E.1; and
 - a. The recommended device, software or application should be capable of modifications to meet the needs for supportive functional communication when possible. The recommended software or application must be compatible with the prescribed SGD.
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- b. Accessories and supplies that do not have a primary medical use will not be covered, which includes any items that are unnecessary for operation of the SGD, or are unrelated to the SGD.
 - i. Covered accessories include but are not limited to:
 - 1. Replacement lithium ion batteries;
 - 2. Non-electric SGD communication board;
 - 3. Mounting systems designated for securing the SGD within reach of the client;
 - 4. Safety and protection accessories designated to maintain the life expectancy of the device,
 - 5. Accessories not otherwise classified may be approved to enhance the use of the SGD system as the member's condition changes; and
 - 6. Orthotic and prosthetic supplies and accessories, and/or service components of another HCPCS L code.
- 4. Other forms of treatment have been considered or ruled out; and
- 5. The member's communication impairment will benefit from the SGD, accessories, or software.

**10 CCR 2505-10, SECTION 8.500-8.599, APPENDIX A: PEDIATRIC PERSONAL CARE SERVICES
BENEFIT COVERAGE STANDARD**

Capitalized terms within this Benefit Coverage Standard that do not refer to the title of a benefit, program, or organization, have the meaning specified in the Definitions section.

A. BRIEF COVERAGE STATEMENT

This Benefit Coverage Standard describes Pediatric Personal Care (PC) Services benefits for Colorado Medicaid clients under 21 years of age. PC Services are Medically Necessary services provided to assist the client with PC Tasks in order to meet the client's physical, maintenance, and supportive needs. This assistance may take the form of Hands-On Assistance, Supervision, or Cuing the client to complete the PC Task.

B. RELATED SERVICES ADDRESSED IN OTHER BENEFIT COVERAGE STANDARDS

1. Home Health
2. Private Duty Nursing

C. ELIGIBLE PROVIDERS

1. Ordering, Prescribing, Referring (OPR) Providers

In accordance with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, all 485 Plans of Care—or other form with identical content—must be signed by one of the following:

- a. Physician
 - i) Doctor of Medicine (MD), or
 - ii) Doctor of Osteopathic Medicine (DO)
- b. Advanced Practice Nurse

2. Personal Care Workers

As a condition of reimbursement, Personal Care Workers (PCW) must meet all of the following requirements:

- a. Not excluded from participation in any federally funded health care programs,
- b. Employed by or providing services under a contract with a licensed Class A or Class B Home Care Agency (HCA) that is enrolled as a Colorado Medicaid provider;
- c. Completion of the Department's PC Services provider training; and has verified experience in the provision of PC Services for clients, as regulated by the Colorado Department of Public Health and Environment (CDPHE) at 6 CCR 1011-1, Chapter 26, Section 8.5.

D. AGENCY REQUIREMENTS

As a condition of reimbursement, Home Care Agencies (HCAs) must meet all of the following requirements:

1. Licensed by the State of Colorado as either a Class A or Class B Agency in good standing;
2. Maintain up-to-date personnel files for each PCW, containing proof of current training, education, and PCW competency, as appropriate to the client's needs and as required by CDPHE; and
3. Comply with the requirements outlined in the Personal Care Worker Supervision section of this Benefit Coverage Standard.

E. ELIGIBLE PLACES OF SERVICE

Pediatric PC Services are covered under this benefit when provided in a client's Residence or outside a client's Residence, subject to the limitations listed in the Non-Covered Services section of this Benefit Coverage Standard.

F. ELIGIBLE CLIENTS

Pediatric PC Services are a benefit for Colorado Medicaid clients who:

1. Are 20 years of age or younger; and
2. Qualify for moderate to total assistance with at least one Personal Care Task

G. GENERAL REQUIREMENTS

For Medicaid clients ages 20 and younger, Pediatric PC Services are covered in accordance with the provisions of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program found at 10 CCR 2505-10 Section 8.280.

1. Requirements of Covered Services

Pediatric PC Services are covered only when:

- a. Medically Necessary, as defined in Colorado Medicaid's EPSDT rule at 10 C.C.R. 2505-10, Section 8.280;
- b. Provided to assist the client with PC Tasks, in order to meet the client's physical, maintenance, and supportive needs;
- c. Provided on an intermittent basis;
- d. Provided for the sole benefit of the client;
- e. Prior authorized and delivered in a manner consistent with professional standards, Colorado licensure requirements, and all other applicable state and federal regulations;
- f. Ordered by a licensed physician, as regulated by the Department of Regulatory Agencies (DORA), or an advanced practice nurse, as licensed by DORA; and

- g. Provided under a current, written 485 Plan of Care, signed by the Ordering Provider.

2. Documentation Requirements

The HCA is required to maintain a record for each client. The record for each client must include all of the following:

- a. A 485 Plan of Care completed by the Ordering Provider. This constitutes a written order for PC services. The 485 Plan of Care must be updated at least annually, or more frequently if required by the needs or condition of the individual client, and must include:
 - i) The frequency of each PC Task required by the client.
 - ii) A range of the frequency for each PC Task required by the client on an as-needed basis. An order for a PC Task “PRN” or “as needed” must be accompanied by a range of the frequency with which the client may require that PC Task to be provided.
 - iii) Documentation or explanation for each PC Task that is required more frequently than the defined Usual Frequency for that task.
- b. Evidence of Care Coordination between the HCAs, when the client is receiving other services from another agency, including but not limited to Medicaid Home Health services, Medicaid HCBS waiver programs, and services from other payers.
- c. Documentation of consultations with relevant medical staff when clients have complex needs or when there are potentially dangerous situations identified.
- d. A written explanation of how the requested PC Services do not overlap with any other services the client is receiving from another agency.
- e. All other client file information, as required by Colorado Medicaid, and by CDPHE, as outlined in rule at 6 C.C.R. 1011-1, Chapter 26, Section 6.20.

H. COVERED SERVICES

Under the description of each task below, Usual Frequency of Task refers to the number of times a typical client is likely to need a task performed. A PC Task will be performed at the usual frequency, unless otherwise specified on the 485 Plan of Care. If a client needs a PC Task performed more frequently than the usual frequency for that PC Task, it must be specified on the 485 Plan of Care.

Covered Pediatric PC Services include assistance with the following PC Tasks:

1. Bathing/Showering

a. Included in Task:

Bathing/shower includes: Preparing bathing supplies and equipment, assessing the water temperature, applying soap (including shampoo), rinsing off, and drying the client; cleaning up after the bath, shower, bed bath, or sponge bath as needed; all transfers and ambulation related to the bathing/showering task; and all hair care, pericare, and skin care provided in conjunction with the bathing/showering task.

b. Usual Frequency of Task: Once daily.

c. Factors that Make Task Personal Care:

Client is able to maintain balance and bear weight reliably, or able to use safety equipment (such as a shower bench) to safely complete the bathing/showering; client's skin is unbroken; client is independent with assistive devices; or when a PCW is assisting a medically-skilled care provider, caregiver, or Unpaid Family Caregiver who is competent in providing this aspect of care.

d. Factors that Make Task Skilled:

There is the presence of open wound(s), stoma(s), broken skin and/or active chronic skin disorder(s); or client is unable to maintain balance or to bear weight reliably due to illness, injury, or disability, history of falls, or a temporary lack of mobility due to surgery or other exacerbation of illness, injury, or disability.

e. Special Considerations:

A second person may be staffed when required to safely bathe the client, when supported by documentation that illustrates that the client requires moderate to total assistance to safely complete this task.

2. Dressing

a. Included in Task:

Dressing includes putting on and taking off clothing, including pantyhose or socks and shoes. Dressing includes getting clothing out and may include braces and splints if purchased over the counter and/or or not ordered by a Qualified Physician.

b. Usual Frequency of Task: Up to two times daily.

c. Factors that Make Task Personal Care:

Client only needs assistance with ordinary clothing and application of support stockings of the type that can be purchased without a physician's prescription; when assistance is needed with transfers and positioning related to dressing and undressing, which may include the cleaning and maintenance of braces, prosthesis, or other DME; or when a PCW is assisting a skilled care provider, caregiver, or Unpaid Family Caregiver who is competent in providing the application of an ace bandage and anti-embolic or pressure stockings or placement of braces or splints that can be obtained only with a prescription of a Qualified Physician, or when the client is unable to assist or direct care.

d. Factors that Make Task Skilled:

Client requires assistance with the application of anti-embolic or pressure stockings, placement of braces or splints that can be obtained only with a prescription of a Qualified Physician, or when the client is unable to assist or direct care. Services may also be skilled when the client experiences a temporary lack of mobility due to surgery or other exacerbation of illness, injury, or disability.

e. Special Considerations:

A PCW may be staffed with a skilled care provider or Unpaid Family Caregiver when required to safely dress the client, and when supported by documentation that illustrates that the client requires moderate to total assistance to safely complete this task.

3. Feeding

a. Included in Task:

Feeding includes ensuring food is the proper temperature, cutting food into bite-size pieces, or ensuring the food is at the proper consistency for the client, up to and including placing food in client's mouth.

b. Usual Frequency of Task: Up to three times daily.

c. Factors that Make Task Personal Care:

The client can independently chew and swallow without difficulty and be positioned upright; the client is able to eat or be fed with adaptive utensils.

d. Factors that Make Task Skilled:

The client requires syringe feeding and tube feeding, which may be performed by a CNA who has been deemed competent to administer feedings via tube or syringe;

Oral feeding when: The client is unable to communicate verbally, non-verbally, or through other means; the client is unable to be positioned upright; the client is on a modified texture diet; the client has a physiological or neurogenic chewing and/or swallowing problem; or when a structural issue (such as cleft palate), or other documented swallowing issue exists.

The client has a history of aspirating food or is on mechanical ventilations that may create a skilled need for feeding assistance, or; when oral suctioning is required.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task. If a client requires snacks in addition to three meals per day, this need must be specified in the 485 Plan of Care.

4. Medication Reminders

a. Included in Task:

Medication Reminders include verbally communicating to a client that it is time for medication, and/or opening and handing a pre-filled medication reminder container to a client.

b. Factors that Make Task Personal Care:

PCWs may assist clients with medication reminders by: inquiring whether medications were taken; verbally prompting the client to take medications; handing the appropriately marked medication reminder container to the client; and opening the appropriately marked medication reminder container for the client if the client is physically unable to open the container.

All medication (prescription medications and all over-the-counter medications) must be pre-selected by the client, the client's Unpaid Family Caregiver, a nurse, CNA, or a pharmacist, and stored in pre-filled medication reminder boxes which are marked with day and time of dosage.

c. Factors that Make Task Skilled:

Medication reminders are PCW tasks unless the client requires services within the scope of a certified CNA.

5. Ambulation/Locomotion

a. Included in Task:

Walking or moving from place to place with or without an assistive device (including wheelchair).

b. Factors that Make Task Personal Care:

A PCW may assist clients with ambulation only if the client has the ability to balance and bear weight reliably, when the client is independent with an assistive device, or when the PCW is assisting a skilled care provider or Unpaid Family Caregiver who is competent in providing the skilled aspect of care.

c. Factors that Make Task Skilled:

Ambulation is considered a skilled task when the client: is unable to assist in the task, direct care, or when hands-on assistance is required for safe ambulation.

The task is also considered skilled when a client is unable to maintain balance, unable to bear weight reliably, or has not been deemed independent with assistive devices ordered by a Qualified Physician.

d. Special Considerations:

Ambulation may not be the standalone reason for a visit. Transferring and positioning into and out of assistive devices is not ambulation, and is addressed in the transferring and positioning section of this standard. Documentation must illustrate the need for moderate to total assistance to safely complete this task.

6. Meal Preparation

a. Included in Task:

Meal preparation includes preparing, cooking, and serving food to a client. Includes formula preparation and ensuring food is a proper consistency based on the client's ability to swallow safely.

b. Usual Frequency of Task: Up to three times daily.

c. Factors that Make Task Personal Care:

All meal preparation is a PC task, except as defined in the Factors that Make Task Skilled portion of this section.

d. Factors that Make Task Skilled:

Meal preparation is considered a skilled task when the client's diet requires nurse oversight to administer correctly. Meals must have a modified consistency.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

7. Hygiene – Hair Care/Grooming

a. Included in Task:

Hair care includes shampooing, conditioning, drying, styling, and combing; it does not include perming, hair coloring, or other styling.

b. Usual Frequency of Task: Up to twice daily.

c. Factors that Make Task Personal Care:

PCWs may assist clients with the maintenance and appearance of their hair. Hair care within these limitations includes: shampooing with non-medicated shampoo or medicated shampoo that does not require a physician's prescription; and drying, combing, and styling of hair.

d. Factors that Make Task Skilled:

Hair care is considered a skilled task when the client requires shampoo or conditioner that is prescribed by a qualified physician and dispensed by a pharmacy; or when the client has one or more open wounds or stomas on the head.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task. Active and chronic skin issues such as dandruff and cradle cap do not make this task skilled.

8. Hygiene – Mouth Care

a. Included in Task:

Mouth care includes brushing teeth, flossing, use of mouthwash, denture care, or swabbing with a toothette.

b. Usual Frequency of Task: Up to three times daily.

c. Factors that Make Task Personal Care:

A PCW may assist and perform mouth care, including denture care and basic oral hygiene.

d. Factors that Make Task Skilled:

Mouth care is considered a skilled task when the client: is unconscious; has difficulty swallowing; is at risk for choking and aspiration; has decreased oral sensitivity or hypersensitivity; has an injury or medical disease of the mouth; is on medications that increase the risk of dental problems, bleeding, injury, or disease of the mouth; or requires oral suctioning.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task. The presence of gingivitis, receding gums, cavities, or other general dental problems does not make mouth care skilled.

9. Hygiene - Nail Care

a. Included in Task:

Nail care includes soaking, filing, and cuticle care.

b. Usual Frequency of Task: Up to one time weekly.

c. Factors that Make Task Personal Care:

A PCW may assist with nail care, which includes soaking of nails, pushing back cuticles with or without utensils, and filing of nails. A PCW may not assist with nail trimming.

d. Factors that Make Task Skilled:

Nail care is considered a skilled task when the client: has a medical condition that involves peripheral circulatory problems or loss of sensation; is at risk for bleeding or is at a high risk for injury secondary to the nail care; or requires nail trimming.

Skilled nail care may only be completed by a CNA who has been deemed competent in nail care for this population.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

10. Hygiene – Shaving

a. Included in Task:

Shaving includes assistance with shaving of face, legs, and underarms with a safety or electric razor.

b. Usual Frequency of Task: Up to one time daily. Task may be completed with bathing or showering.

c. Factors that Make Task Personal Care:

A PCW may assist a client with shaving with an electric or a safety razor.

d. Factors that Make Task Skilled:

Shaving is considered a skilled task when the client: has a medical condition that involves peripheral circulatory problems or loss of sensation; has an illness or takes medications that are associated with a high risk for bleeding; has broken skin at or near shaving site; has a chronic active skin condition; or is unable to shave him or herself.

e. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

11. Hygiene – Skin Care

a. Included in Task:

Skin care includes applying lotion or other skin care products, only when not completed in conjunction with bathing or toileting (bladder or bowel). May be provided in conjunction with positioning.

b. Factors that Make Task Personal Care:

A PCW may provide general skin care assistance only when a client's skin is unbroken and when no chronic skin problems are active.

The skin care provided by a PCW must be preventive, rather than therapeutic, in nature. It includes the application of skin care lotions and solutions not requiring a physician's prescription.

c. Factors that Make Task Skilled:

Skin care is considered a skilled task when the client: requires skin care lotions or solutions requiring a physician's prescription; has broken skin, wound(s), or an active chronic skin problem; or is unable to apply product independently due to illness, injury, or disability.

d. Special Considerations:

Skin care completed in conjunction with bathing and toileting, as ordered on the 485 Plan of Care, is not included in this task. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

12. Toileting – Bowel Care

a. Included in Task:

Bowel Care includes changing and cleaning an incontinent client, or providing hands-on assistance with toileting. This includes returning the client to pre-bowel movement status, transfers, skin care, ambulation, and positioning related to elimination.

b. Factors that Make Task Personal Care:

A PCW may assist a client to and from the bathroom; provide assistance with bedpans and commodes; provide pericare; or change clothing and pads of any kind used for the care of incontinence.

A PCW may assist a skilled care provider or Unpaid Family Caregiver who is competent in providing this aspect of care.

c. Factors that Make Task Skilled:

Bowel Care is considered a skilled task when: the client is unable to assist or direct care; has broken skin or recently healed skin breakdown (less than 60 days); requires skilled skin care associated with bowel care; or has been assessed as having a high and ongoing risk for skin breakdown.

d. Special Considerations:

A PCW may be aided by a skilled care provider or Unpaid Family Caregiver when required to safely complete Bowel Care with the client. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

13. Toileting – Bowel Program

a. Included in Task:

Bowel Program includes emptying the ostomy bag, as ordered by the client's Ordering Provider. This includes skin care at the site of the ostomy and returning the client to pre-bowel program status.

b. Factors that Make Task Personal Care:

A PCW may empty ostomy bags and provide client-directed assistance with other ostomy care only when there is no need for skilled bowel program care, for skilled skin care, or for observation or reporting to a nurse.

A PCW may not perform digital stimulation, insert suppositories, or give an enema.

c. Factors that Make Task Skilled:

Bowel Program is considered a skilled task when: the client requires the use of digital stimulation, suppositories, or enemas; or when the client requires skilled skin care at the ostomy site.

d. Special Considerations:

Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

14. Toileting – Catheter Care

a. Included in Task:

Catheter Care includes perineal care and emptying catheter bags. This includes transfers, skin care, ambulation, and positioning related to catheter care.

b. Usual Frequency of Task: Up to two times a day.

c. Factors that Make Task Personal Care:

A PCW may empty urinary collection devices such as catheter bags when there is no need for observation or reporting to a nurse; and provide pericare for clients with indwelling catheters.

d. Factors that Make Task Skilled:

Catheter Care is considered a skilled task when: emptying indwelling or external urinary collection devices and there is a need to record and report the client's urinary output to the client's nurse; task involves insertion, removal, and care of all catheters; changing from a leg to a bed bag and cleaning of tubing and base; or if the indwelling catheter tubing needs to be opened for any reason and the client is unable to do so independently.

e. Special Considerations:

Catheter Care may not be the sole purpose of the visit. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

15. Toileting – Bladder Care

a. Included in Task:

Bladder Care includes assistance with toilet, bedpan, urinal, or diaper use, as well as emptying and rinsing the commode or bedpan after each use. This includes transfers, skin care, ambulation, and positioning related to bladder care. This task concludes when the client is returned to his or her pre-urination state.

b. Factors that Make Task Personal Care:

A PCW may assist a client to and from the bathroom, provide assistance with bedpans, urinals, and commodes; provide pericare; and change clothing and pads of any kind used for the care of incontinence.

c. Factors that Make Task Skilled:

Bladder care is considered a skilled task when the client: is unable to assist or direct care; has broken skin or recently healed skin breakdown (less than 60 days); requires skilled skin care associated with bladder care; or has been assessed as having a high and ongoing risk for skin breakdown.

d. Special Considerations:

A PCW may assist a skilled care provider or Unpaid Family Caregiver who is competent in providing this aspect of care. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

16. Mobility – Positioning

a. Included in Task:

Positioning includes moving the client from a starting position to a new position while maintaining proper body alignment and support to a client's extremities, and avoiding skin breakdown.

b. Factors that Make Task Personal Care:

A PCW may assist a client with positioning when the client is able to identify to the provider, verbally, non-verbally, or through other means including but not limited to, a legally responsible adult or adaptive technologies, when his or her position needs to be changed, and only when skilled skin care is not required in conjunction with positioning. Positioning includes alignment in a bed, wheelchair, or other furniture; and the placement of padding required to maintain proper alignment. The PCW may receive direction from or assist a skilled care provider or Unpaid Family Caregiver who is competent in providing this aspect of care.

c. Factors that Make Task Skilled:

Positioning is considered a skilled task when the client is: unable to communicate verbally, non-verbally, or through other means; or unable to perform this task independently due to illness, injury, disability, or temporary lack of mobility due to surgery. Positioning includes adjusting the client's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a Qualified Physician.

d. Special Considerations:

Positioning and padding may not be the sole purpose for the PC visit. Positioning is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care, or other PC Tasks that require positioning.

If PC positioning is required for the completion of a skilled care task, visits must be coordinated to effectively schedule these services. A PCW may be accompanied by a skilled care provider or Unpaid Family Caregiver when required to safely position the client. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

17. Mobility - Transfer

a. Included in Task:

Transfers include moving the client from a starting location to a different location in a safe manner. It is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care, or other PC Task.

b. Factors that Make Task Personal Care:

A PCW may assist with transfers only when the client has sufficient balance and strength to reliably stand, pivot, and assist with the transfer to some extent. Adaptive equipment, including, but not limited to, wheelchairs, tub seats, and grab bars, and safety devices may be used in transfers if: the client and PCW are fully trained in the use of the equipment; the client, or client's Unpaid Family Caregiver, can direct the transfer step-by-step; or when the PCW is deemed competent by the employer HCA in the specific transfer technique for the client. A gait belt may be used in a transfer as a safety device if the PCW has been properly trained in its use. A lift is not an included safety device and may not be used in PC transfers.

c. Factors that Make Task Skilled:

Transfers are considered a skilled task when the client: is unable to communicate verbally, non-verbally, or through other means; is not able to perform this task independently due to illness, injury, disability, or temporary lack of mobility due to surgery; lacks the strength and stability to stand or bear weight reliably; is not deemed independent in the use of assistive devices or Durable Medical Equipment that has been ordered by a Qualified Physician; or when the client requires a mechanical lift, such as a Hoyer lift, for safe transfer. In order to transfer clients via a mechanical lift, the CNA must be deemed competent in the particular mechanical lift used by the client.

d. Special Considerations:

Transfers may be completed with or without mechanical assistance. Transferring shall not be the sole purpose for the visit. A transfer is not considered a separate task when performed in conjunction with bathing, bladder care, bowel care, or other PC Task. A PCW may be aided by a skilled care provider or Unpaid Family Caregiver when required to safely transfer the client. A PCW may assist the Unpaid Family Caregiver with transferring the client, provided the client is able to direct and assist with the transfer. Documentation must illustrate that the client needs moderate to total assistance to safely complete this task.

I. LIMITATIONS

1. Medicaid clients ages 21 and older are not eligible for Pediatric PC Services.
2. The use of physical Behavioral Interventions such as restraints is prohibited, per CDPHE's consumer rights regulations. 6 C.C.R. 1011-1, Chapter 26, Section 6.
3. All PCWs and HCAs must comply with all applicable Colorado and federal requirements, rules, and regulations.
4. All Pediatric PC Services will be reimbursed at the Medicaid Pediatric PC Services rate, regardless of whether the PCW providing PC Services holds credentials for CNA, RN, or other skilled profession.
5. If a client requires a Skilled Transfer to complete a PC Task, the associated PC Task will be considered skilled in nature. PC Tasks considered skilled in nature are not covered PC Services, and will not be reimbursed by Colorado Medicaid under the Pediatric PC Services benefit.
6. PC Tasks provided as required components of skilled care tasks are not covered PC Services, and will not be reimbursed by Colorado Medicaid under the Pediatric PC Services benefit.
7. Clients eligible for the Pediatric PC Services benefit who are also eligible for the Colorado Department of Human Services Home Care Allowance program, described in rule at 9 C.C.R. 2503-5, Section 3.570, may receive services through one program, but not both.
8. If a PC Task is provided to a client by a PCW and a Skilled Care worker, but only one staff person is required, the PCW will not be reimbursed by Colorado Medicaid under the Pediatric PC Services benefit.
9. If a PC Task is provided to a client by two PCWs from different HCAs, but only one PCW is required, Colorado Medicaid will reimburse solely the HCA with a history of providing that particular PC Task to the client.
10. Two staff may be reimbursed for the same PC service for a client only when two people are required to safely provide the service, two staff were approved by prior authorization for the service, and there is no other person available to assist in providing this service.
11. HCAs may decline to perform a specific task or service, regardless of whether the task is a covered Pediatric PC Service, if the supervisor or the PCW documents a concern regarding the safety of the client or the PCW.

J. PERSONAL CARE WORKER SUPERVISION

1. PCWs must periodically receive onsite supervision by a Registered Nurse, the clinical director, home care manager, or other home care employee who is in a designated supervisory capacity and is available to the PCW at all times. This onsite supervisory visit must occur at least every 90 days, or more often as necessary for problem resolution, skills validation of the PCW, client-specific or procedure-specific training of the PCW, observation of client's condition and care, and assessment of client's satisfaction with services. At least one of the assigned PCWs must be present at the onsite supervisory visit.
2. Each PCW must have a complete and up-to-date personnel file that demonstrates that the PCW has:
 - a. Signed and dated evidence that he/she has received training and orientation on the HCA's written policies and procedures;
 - b. Signed and dated evidence that he/she has received training and is competent to provide the client's specific PC Tasks;
 - c. A signed and dated job description that clearly delineates his/her responsibilities and job duties;
 - d. Proof that he/she is current and up to date on all training and education required by CDPHE at 6 C.C.R. 1011-1 Chapter 26, Section 8.6;
 - e. Signed and dated competency information regarding training and skills validation for client-specific personal care and homemaking tasks;
 - f. Signed and dated evidence that he/she has been instructed in basic first aid, and training in infection control techniques, including universal precautions;
 - g. Information on any complaints received regarding the PCW, and documentation on the outcome and follow-up of the complaint investigation.

K. PRIOR AUTHORIZATION REQUEST (PAR) REQUIREMENTS

1. Approval of the PAR does not guarantee payment by Medicaid. The presence of an approved or partially approved PAR does not release the HCA from the requirement to bill Medicare or other third party insurance prior to billing Medicaid.
2. All Pediatric PC Services require prior authorization by Colorado Medicaid or its Designated Review Entity using the approved utilization management tool.
3. Pediatric PC Services PARs may be submitted for up to a full year of anticipated services unless: the client is not expected to need a full year of services; the client's eligibility is not expected to span the entire year; or as otherwise specified by Colorado Medicaid or its Designated Review Entity.
4. A PAR will be pended by Colorado Medicaid or its Designated Review Entity if all of the required information is not provided in the PAR, or additional information is required by the Designated Review Entity to complete the review.
5. PARs must be submitted to Colorado Medicaid or its Designated Review Entity in accordance with 10 CCR 2505-10 § 8.058.

6. It is the HCA's responsibility to provide sufficient documentation to support the medical necessity for the requested services.
7. When a PAR includes a request for reimbursement for two staff members at the same time (excluding supervisory visits) to perform two-person transfers or another PC Task, documentation supporting the need for two people and the reason adaptive equipment cannot be used must be included.
8. All other information determined necessary by Colorado Medicaid or its Designated Review Entity to review a request and the appropriateness of the proposed treatment plan must be provided.

L. NON-COVERED SERVICES

The following services are not covered under the Pediatric PC Services benefit:

1. Services that are not prior authorized by the Colorado Medicaid Designated Review Entity;
2. In accordance with Section 1905(a) of the Social Security Act, any services provided by the client's parents, foster parents, legal guardians, spouses, and other persons legally responsible for the well-being of the client;
3. Services provided by an individual under 18 years of age;
4. Services provided by a person not employed by the HCA;
5. Services provided through an Individual Residential Services and Supports (IRSS) or Group Residential Services and Supports (GRSS) program; or in any Medicaid-reimbursed setting, including, but not limited to medical offices, hospitals, hospital nursing facilities, alternative care facilities, and Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID).
6. PC Services that are covered under the client's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP);
7. Tasks that are defined as Skilled Care Services in the Home Health Services Rule at 10 CCR 2505-10 § 8.520;
8. Homemaker services, or tasks that are performed to maintain a household. These tasks are considered to be non-medical tasks and include grocery shopping, laundry, and housekeeping;
9. Exercise and range of motion services;
10. Protective Oversight services.
11. Services provided for the purpose of companionship, respite, financial management, child care, education, or home schooling; for the benefit of someone other than the Medicaid client; that are not justified by the documentation provided by the client's medical or functional condition (even when services have been prior authorized); or that are not appropriate for the client's needs;
12. Visits that occur for the sole purpose of supervising or training the PCW;

13. Any services that are reimbursable by another insurance agency or other state, federal, or private program;
14. PC Services provided during a Skilled Care Services visit;
15. Services provided by the client's Unpaid Family Caregiver; or
16. Assistance with services that are being provided as a reasonable accommodation as part of the Americans with Disabilities Act (ADA), the Rehabilitation Act of 1973, or Part B of the Individuals with Disabilities Education Act (IDEA).

M. DEFINITIONS

The following definitions are applicable only within the scope of this Benefit Coverage Standard.

485 Plan of Care. Refers to a CMS-485 Home Health Certification and Plan of Care, or a form that is identical in content. A 485 Plan of Care is a coordinated plan developed by the Home Care Agency as ordered by the Ordering Provider for provision of services to a client, and periodically reviewed and signed by the physician in accordance with Medicare requirements.

Behavioral Intervention. Techniques, therapies, and methods used to modify or minimize verbally or physically aggressive, combative, destructive, disruptive, repetitious, resistive, self-injurious, sexual, or otherwise inappropriate behaviors outlined on the 485 Plan of Care. Behavioral Interventions exclude frequent verbal redirection or additional time to transition or complete a task, which are part of the general service to the client's needs.

Care Coordination. The planned organization of client care tasks between two or more participants (including the client) involved in a client's care to facilitate the appropriate delivery of health care and other health care support services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required client care tasks, and is managed by the exchange of information among participants responsible for different aspects of care with the understanding that this information is or will be incorporated into the current or future medical care of the client.

Centers for Medicare and Medicaid Services (CMS). The federal government agency that works with states to run the Medicaid program. CMS is also responsible for the Medicare program.

Certified Nurse Aide (CNA). An employee of a Home Health Agency with a CNA certification. A CNA must have a current, active Colorado CNA certification and be employed by a Class A Home Health Agency. The CNA must have completed all required continuing education and training and have verified experience in the provision of Skilled Care Services.

Class A Agency. A Home Care Agency that provides any Skilled Care Service. Class A Agencies may also provide Personal Care Services.

Class B Agency. A Home Care Agency that provides only Personal Care Services. Class B Agencies may not provide any Skilled Care Services.

Colorado Medicaid. Colorado Medicaid is a free or low-cost public health insurance program that provides health care coverage to low-income individuals, families, children, pregnant women, seniors, and people with disabilities. Colorado Medicaid is funded jointly by the federal and state government, and is administered by the Colorado Department of Health Care Policy and Financing.

Cuing. Providing a prompt or direction to assist a client in performing PC Tasks he/she is physically capable of performing but unable to independently initiate.

Designated Review Entity. An entity that has been contracted by the Department to review Prior Authorization Requests (PARs) for medical necessity and appropriateness.

Exacerbation. A sudden or progressive increase in severity of a client's condition or symptoms related to a chronic illness, injury, or disability.

Hands-On Assistance. Performing a personal care task for a client.

Home Care Agency (HCA). Refers collectively to Class A Agencies, which provide Home Health Services, and Class B agencies, which provide Personal Care Services. Home Care Agency is defined in full at 6 CCR 1011-1, Chap. 26 § 3.11. When used in this Benefit Coverage Standard without a Class A or Class B designation, the term encompasses both types of agency.

Home Health Agency (HHA). An agency that is licensed as a Class A Home Care Agency in Colorado that is Medicare certified to provide Skilled Care Services. Agencies must be actively enrolled as a Medicare and Medicaid Home Health provider in order to provide services to Medicaid clients. An agency that is licensed as a Class A Home Care Agency may also provide Personal Care Services based on the agency's policies and procedures.

Home Health Services. Services and care that, due to the inherent complexity of the service, can only be performed safely and correctly by a trained and licensed/certified nurse (RN or LPN), therapist (PT, OT, or SLP), or CNA.

Homemaker Services. General household activities provided in the Residence of an eligible client in order to maintain a healthy and safe home environment for the client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

Intermittent Basis. Personal Care Services visits that have a distinct start time and stop time and are task-oriented with the goal of meeting a client's specific needs for that visit.

Medically Necessary. Medical Necessity for Pediatric Personal Care Services is defined at 10 C.C.R. 2505-10, § 8.280.1.

Ordering Provider. A client's primary care physician, personal physician, advanced practice nurse, or other specialist who is responsible for writing orders and overseeing the client's 485 Plan of Care. This may include an alternate physician who is authorized by the Ordering Provider to care for the client in the Ordering Provider's absence.

Personal Care Agency (PCA). A Class B Home Care Agency that is licensed by the Colorado Department of Public Health and Environment.

Personal Care (PC) Services. The provision of assistance, hands-on support with, or supervision of specific Personal Care Tasks to assist clients with activities of daily living.

Personal Care (PC) Tasks. Any of 17 daily living tasks described in the PC Benefit Coverage Standard.

Personal Care Worker (PCW). An employee of a licensed Home Care Agency who has completed the required training to provide Personal Care Services, or who has verified experience in the provision of Personal Care Services for clients, as regulated by the Colorado Department of Public Health and Environment at 6 C.C.R. 1011-1 Section 8.6. A client's Unpaid Family Caregiver cannot be a PCW for that client.

Prior Authorization Request (PAR). A PAR is a request for determination that covered Medicaid services are medically necessary.

Protective Oversight. Monitoring a client to reduce or minimize the likelihood of injury or harm due to the nature of the client's injury, illness, or disability.

Qualified Physician. A primary care physician, personal physician, or other specialist who is currently licensed and in good standing.

Rendering Provider. The provider administering the service.

Residence. The physical structure in which the client lives. The Residence may be temporary or permanent. A Residence may be the client's own house, an apartment, a relative's home, or other temporary accommodation where the client resides. The Residence may not be a nursing facility or other institution, as defined by CMS and the State of Colorado.

Skilled Care Services. Services and care that, due to the inherent complexity of the service, can only be performed by a trained and licensed/certified nurse (RN or LPN), therapist (PT, OT or SLP), or CNA.

Skilled Nursing Services. Services provided by an actively licensed Registered Nurse, and services provided by a Licensed Practical Nurse under the direction of a Registered Nurse, in accordance with applicable state and federal laws, including but not limited to the Colorado Nurse Practice Act §§ 12-38-101 to -133, C.R.S., and 42 C.F.R 484.30.

Skilled Transfer. Supporting or enabling the movement of a client from place to place when the client does not have sufficient balance and strength to reliably stand and pivot and assist with the transfer to some extent. Adaptive and safety equipment may be used in transfers, provided that the skilled care worker is fully trained in the use of the equipment.

State Plan. An agreement between Colorado and the federal government describing how the Department administers its Medicaid program. The State Plan sets out groups of individuals to be covered, services to be provided, and the methodologies for providers to be reimbursed. It gives an assurance that the Department will abide by federal rules and may claim federal matching funds for its program activities.

Supervision. The act of ensuring that a client is performing a PC Task correctly and safely. Supervision may include actively intervening to ensure that a PC Task is completed without injury.

Unpaid Family Caregiver. A person who provides care to a client without reimbursement by the Department or other entity. Family members of a client will not be reimbursed by the Department for care provided to that client. Family members include, but are not limited to, parents, foster parents, legal guardians, spouses, and other persons legally responsible for the well-being of the client.

Usual Frequency of Task. The number of times a typical person is likely to need a task performed. A task will be performed at the Usual Frequency, unless otherwise specified on the 485 Plan of Care.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 3/4/07, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 3/4/07, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]