DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Update Inpatient Base Rates for fiscal year 22-23, Section 8.300.5
Rule Number: MSB 22-01-06-B
Division / Contact / Phone: Rates Division / Diana Lambe / 5526

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-01-06-B, Revision to the Medical Assistance Rule concerning Update Inpatient Base Rates for fiscal year 22-23, Section 8.300.5.

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) OP Pages, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the text at 8.300.5.A.3.e with the proposed text beginning at 8.300.5.A.3.e through the end of 8.300.A.3.e. This rule is effective May 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Update Inpatient Base Rates for fiscal year 22-23, Section 8.300.5
Rule Number: MSB 22-01-06-B
Division / Contact / Phone: Rates Division / Diana Lambe / 5526

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The rules authorizing the annual adjustment schedule for Inpatient Hospital Base Rates, 10 CCR 2505-10, Section 8.300.5.A.3.e will be modified to allow the rates to be updated using the State Budget Action as defined by the Legislature for State Fiscal Year 2022-23.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. § 447.253(b)(1).

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. & 25.5-4-402, C.R.S. (2021)

Initial Review **03/11/22** Final Adoption **04/08/22**
Proposed Effective Date **05/30/22** Emergency Adoption

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Update Inpatient Base Rates for fiscal year 22-23, Section 8.300.5
Rule Number: MSB 22-01-06-B
Division / Contact / Phone: Rates Division / Diana Lambe / 5526

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   No classes of persons will be affected by the proposed rules.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   No classes of persons will be affected by the proposed rules.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no expected increases or decreases of Department revenues associated with this rule change.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The cost of inaction will be in the form of 4-6 months' worth of time that will be taken away from building the new inpatient base rate methodology with a target implementation of 7/1/2023.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   No other methods will achieve the purpose required.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   This rule change is necessary to update the annual update schedule for fiscal year 2022-2023.

8.300 HOSPITAL SERVICES

8.300.5 Payment for Inpatient Hospital Services

8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services

1. Peer Groups

   For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups. Hospitals which do not fall into the peer groups described in a and b shall default to the peer groups described in c and d based on geographic location.:

   a. Pediatric Hospitals

   b. Urban Safety Net Hospitals

   c. Rural Hospitals

   d. Urban Hospitals

2. Base Payment and Outlier Payment

   DRG Hospitals shall be reimbursed for Inpatient Hospital Services based on a system of DRGs and a hospital-specific Medicaid Inpatient base rate. The reimbursement for Inpatient Hospital Services shall be referred to as the DRG base payment.

   a. The DRG base payment shall be equal to the DRG Relative Weight multiplied by the Medicaid Inpatient base rate as calculated in 10 CCR 2505-10 Section 8.300.5.A.3 – 6.

   b. Outlier days shall be reimbursed at 80% of the DRG per diem rate. The DRG per diem rate shall be the DRG base payment divided by the DRG average length of stay.

   c. The DRG base payment plus any corresponding outlier payment is considered the full reimbursement for an Inpatient Hospital stay where the client was Medicaid-eligible for the entire stay.

   d. When a client was not Medicaid-eligible for an entire Inpatient Hospital stay, reimbursement shall be equal to the DRG per diem rate for every eligible day, with payment up to the full DRG base payment. If applicable, the Hospital shall receive outlier reimbursement.

3. Medicaid Inpatient Base Rate for In-network Colorado DRG Hospitals

   a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate

      i For in-network Colorado DRG Hospitals, excluding Rehabilitation Hospitals, Long-Term Care Hospitals, CAHs, Pediatric Hospitals, and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the hospital-specific Medicare Federal base rate minus any DSH factors. For the purpose of rate setting effective on July 1 of each fiscal year, the

Medicare base rate used shall be the Medicare base rate effective on October 1 of the previous fiscal year.

ii For Pediatric Hospitals, the starting point shall be equal to the cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 for rates effective July 1 of the same calendar year.

iii For CAHs and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the average Medicare base rate minus DSH factors for their respective peer group. The average calculation shall exclude CAHs and those Hospitals with less than twenty Medicaid discharges in the previous fiscal year.

b. Application of Adjustment Based on General Assembly Funding

For all in-network, Colorado DRG Hospitals, excluding Urban Safety Net Hospitals, the starting point for the Medicaid Inpatient base rate, as determined in 10 CCR 2505-10 Section 8.300.5.A.3.a, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Urban Safety Net Hospitals' starting point shall be adjusted by the percentage applied to all other Hospitals plus 10 percent. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent.

c. Application of Cost Add-ons to Determine Medicaid Inpatient Base Rate

i The Medicaid Inpatient base rate shall be equal to the rate as calculated in 10 CCR 2505-10 Sections 8.300.5.A.3.a and 8.300.5.A.3.b, plus any Medicaid hospital-specific cost add-ons. The Medicaid hospital-specific cost add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1. Partial year cost reports shall not be used to calculate the cost add-ons.

ii The Medicaid hospital-specific cost add-ons shall be an estimate of the cost per discharge for nursery, neo-natal intensive care units, and Graduate Medical Education (GME). The GME cost add-on information shall be obtained from the audited Medicare/Medicaid cost report, worksheet B, part I; discharges from worksheet S-3, part I, nursery and neo-natal costs, shall be obtained from the audited Medicare/Medicaid cost report, Title XIX in worksheet D-1, part II. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in 10 CCR 2505-10 Section 8.300.9.2.

iii Ten percent of the Medicaid hospital-specific cost add-ons shall be applied.

d. Application of Adjustments for Certain Hospitals

For Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals, the Medicaid Inpatient base rate shall receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.

e. Annual Adjustments

The Medicaid Inpatient base rates are adjusted annually (rebased) and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department. For fiscal year 21-22, the Medicaid Inpatient Base Rates from fiscal year 20-21 will be adjusted by the percentage change in the budget as appropriated by the General Assembly. For fiscal year 22-23, the Medicaid Inpatient Base Rates from fiscal year 21-22 will be adjusted by the percentage change in the budget as appropriated by the General Assembly.

4. Medicaid Inpatient Base Rate for New In-Network Colorado DRG Hospitals

The Medicaid Inpatient base rate for new in-network Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing period after the Hospital's contract effective date. For the next Inpatient rate rebasing period, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in 10 CCR 2505-10 Section 8.300.5.A.3. If the Hospital does not have a Medicare Inpatient base rate or an audited Medicare/Medicaid cost report to compute a starting point as described in 10 CCR 2505-10 Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

The Medicaid Inpatient base rate for border-state Hospitals shall be equal to the average Medicaid Inpatient base rate for the corresponding peer group.

6. Medicaid Inpatient Base Rate for Out-of-network Hospitals

a. The Medicaid Inpatient base rate for out of network Hospitals, including out-of-state Hospitals, shall be equal to 90% of the average Medicaid Inpatient base rate for the corresponding peer group.

b. The Department may reimburse an out-of-state Hospital for non-emergent services at an amount higher than the DRG base payment when the needed services are not available in a Colorado Hospital. Reimbursement to the out-of-state Hospital shall be made at a rate mutually agreed upon by the parties involved.

7. Reimbursement for Inpatient Hospital claims that (a) include serious reportable events identified by the Department in the Provider Bulletin with (b) discharge dates on or after October 1, 2009, may be adjusted by the Department.

8.300.5.B Abbreviated Client Stays

1. DRG Hospitals shall receive the DRG base payment and any corresponding outlier payment for Abbreviated Client Stays. The DRG base payment and outlier payment shall be subject to any necessary reduction for ineligible days.

8.300.5.C Transfer Pricing

1. Reimbursement for a client who is transferred from one DRG Hospital to another DRG Hospital is calculated at a DRG per diem rate for each Hospital with payment up to the DRG base payment to each DRG Hospital. If applicable, both Hospitals may receive outlier reimbursement.

2. Reimbursement for a client who is transferred from one DRG Hospital to a Non-DRG Hospital, or the reverse, is calculated at the DRG per diem rate for the DRG Hospital with payment up to the

DRG base payment. Reimbursement for the Non-DRG Hospital shall be calculated based on the assigned per diem rate. If applicable, the DRG Hospital may receive outlier reimbursement.

3. For transfers within the DRG Hospital, the Hospital is required to submit one claim for the entire stay, regardless of whether or not the client has been transferred to different parts of the Hospital. Since the Colorado Medicaid program does not recognize distinct part units, Hospitals may not submit two claims for a client who is admitted to the Hospital and then transferred to the distinct part unit or vice versa.

8.300.5.D Long-Acting Reversible Contraceptives Exclusion

1. Long-acting reversible contraceptives (LARC) devices, inserted following a delivery, are excluded from the DRG Relative Weight calculation and are paid according to the Department's fee schedule.

8.300.5.E Payments to Non-DRG Hospitals for Inpatient Services

1. Payments to Psychiatric Hospitals

   a. The Department shall reimburse Psychiatric Hospitals for inpatient services provided to Medicaid clients on a per diem basis. The per diem rates shall follow a step-down methodology. Each step has a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. Criteria for each step are described below:

      i Step 1: Day 1 through Day 7

      ii Step 2: Day 8 through remainder of care at acute level

   b. Hospital rates may be adjusted annually on July 1 to account for changes in funding by the General Assembly and inflationary adjustments as determined by the Medicare Economic Index.

2. Payment to State-Owned Psychiatric Hospitals

   The Department shall reimburse State-Owned Psychiatric Hospitals on an interim basis according to a per diem rate. The Department will determine the per diem rate based on an estimate of 100% of Medicaid costs from the Hospital's Medicare cost report. Periodically, the Department will audit actual costs and may require a cost settlement to insure reimbursement is 100% of actual audited Medicaid costs.

3. Payments to Long-Term Care and Rehabilitation Hospitals (excludes distinct part units and satellite locations as defined under 10 CCR 2505 10 8.300) shall be divided into three (3) subgroups: Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital.

   The Department shall reimburse Long-Term Care, Rehabilitation, and Spine/Brain Injury Treatment Specialist Hospitals for inpatient services provided to Medicaid patients on a per diem basis. The per diem rates shall follow a step-down methodology based on length of stay, with a decrease of five (5) percent with each step. Each step shall be assigned a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. The Department may adjust hospital rates annually on July 1 to account for changes in funding by the General Assembly. The criteria for each of the steps are described below:

a. Payments to Long-Term Care Hospitals:

i. Step 1: Day 1 through Day 21

ii. Step 2: Day 22 through Day 35

iii. Step 3: Day 36 through Day 56

iv. Step 4: Day 57 through remainder of stay

b. Payments to Rehabilitation Hospitals:

i. Step 1: Day 1 through Day 6

ii. Step 2: Day 7 through Day 10

iii. Step 3: Day 11 through Day 14

iv. Step 4: Day 14 through remainder of stay

c. Payments to Spine/Brain Injury Treatment Specialty Hospitals:

i. Step 1: Day 1 through Day 28

ii. Step 2: Day 29 through Day 49

iii. Step 3: Day 50 through Day 77

iv. Step 4: Day 78 through remainder of stay

d. The Classification-specific per diem for 2019, the year of this methodology implementation shall be calculated using the following method:

i. The Department shall assign the claims submitted by each hospital for fiscal year 2017 to one of the following peer groups:

1) Long-Term Care Hospital

2) Rehabilitation Hospital

3) Spine/Brain Injury Treatment Specialty Hospital

ii. The Department shall process Medicaid inpatient hospital claims from state fiscal year 2017 through the methodology described in Section 8.300.5.D.3 a-c. This will create per diems that are budget neutral to fiscal year 2017.

iii. The Department shall adjust the per diems annually to reflect budget changes. For state fiscal year 2018, rates shall be increased 1.4%. For state fiscal year 2019, rates shall be increased 1%. The Department shall adjust rates in subsequent years by the percentage changes in the budget as appropriated by the General Assembly.

8.300.5.E [Emergency rule expired 04/10/2021]

8.300.5.F Payment for Inpatient Subacute Care

1. Inpatient Subacute Care days shall be paid at a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved by the Centers for Medicare and Medicaid Services (CMS), for the State in which such hospital is located.

8.300.5.G Payment for High Acuity In-State Services

1. The Department may negotiate a higher reimbursement rate for in-state inpatient hospital services where:

    a. The in-state inpatient payment methodology insufficiently accounts for the level of acuity;

    b. All other placement options have been exhausted; and

    c. The services have been reviewed and authorized by the Medical Director for the Department.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the MedicaL Assistance Rules concerning the Participant Directed Programs Rules, Sections 8.510 & 8.552.
Rule Number: MSB 22-01-10-A
Division / Contact / Phone: Benefits and Services Management / Erin Thatcher / 5788

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB Revisions to the MedicaL Assistance Rules concerning the Participant Directed Programs Rules, Sections 8.510 & 8.552, Revisions to the Participant Directed Programs Rules, Sections 8.510 & 8.552.

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.510 and 8.552, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the text at 8.510.8 with the proposed text beginning at 8.510.8.A through the end of 8.510.8.A.1. Replace the text at 8.552.6 with the proposed text beginning at 8.552.6.K.1 through the end of 8.552.6.K.1. This rule is effective May 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the MedicaL Assistance Rules concerning the Participant Directed Programs Rules, Sections 8.510 & 8.552.
Rule Number: MSB 22-01-10-A
Division / Contact / Phone: Benefits and Services Management / Erin Thatcher / 5788

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule changes the minimum attendant age from 18 to 16 years of age in Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS). This rule is necessary to ensure that members have access to a larger pool of prospective attendants to provide attendant services in home and community settings and will prevent unnecessary institutionalization.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   n/a

3. Federal authority for the Rule, if any:

   Colorado Combined Appendix K Approval which can befound at https://www.medicaid.gov/state-resource-center/downloads/cocombined-appendix-k-appvl.pdf, pages 17 – 18.

4. State Authority for the Rule:

   Sections 25.5-6-11 and 25.5-6-12, C.R.S. (2021)
   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021)
   C.R.S. § 25.5-6-1102 (2021)

Initial Review **03/11/22** Final Adoption **04/08/22**
Proposed Effective Date **05/30/22** Emergency Adoption

DOCUMENT #10

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the MedicaL Assistance Rules concerning the Participant Directed Programs Rules, Sections 8.510 & 8.552.
Rule Number: MSB 22-01-10-A
Division / Contact / Phone: Benefits and Services Management / Erin Thatcher / 5788

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members receiving Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS) will be affected by the proposed rule. Members will be permitted to receive attendant services from minor attendants at least 16 years of age or older. Employers will be permitted to hire minors to complete attendant services if they choose. Attendants will have the ability to work in the health care field providing homemaker, personal care, and health maintenance activities.

   There are no costs to members associated with this change. Some IHSS providers might experience a change in liability insurance costs that could influence their decision to hire minors.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   By removing barriers for participant-directed program employers to recruit and hire minor attendants aged 16-17 years of age, this will help ensure that members can continue living independently in their homes with attendant support services. It is imperative that participant-directed employers can remain competitive in recruiting and retaining workers. The growing workforce shortage has impacted members in participant direction, as they are responsible for recruiting new attendants and don't often have the resources or capacity to compete against larger industries or businesses.

   With this change, it is important to highlight that promoting safety and safe work environments is a crucial component of the employment of minor attendants. The Department will provide access to supplemental training and resources to help employers manage and supervise minor workers. In addition, minor attendants will receive extensive training on service provision and program guidelines. Minor attendants will not be permitted to operate lift equipment in CDASS and IHSS per Child Labor Hazardous Occupations Order No. 7 (29 CFR § 570.58).

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3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs associated with implementation of this change, therefore there is no budgetary impact. The Department's vendors will help to support these changes through their existing contracts and funding.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   If the Department does not implement this rule change, there will be adverse impacts to members who continue to face difficulty hiring attendants. Members without attendants to provide services in the home and community may be forced into institutional settings. This provides an option for employers who are increasingly burdened in this workforce crisis.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for achieving the goals of this rule change.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There is no alternative method available for this amendment.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

A. Adaptive Equipment means one or more devices used to assist with completing activities of daily living.

B. Allocation means the funds determined by the Case Manager in collaboration with the Client and made available by the Department through the Financial Management Service (FMS) vendor for Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option.

C. Assessment means a comprehensive evaluation with the Client seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the Client's medical provider to determine the Client's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department's prescribed tool to complete assessments.

D. Attendant means the individual who meets qualifications in 8.510.8 who provides CDASS as described in 8.510.3 and is hired by the Client or Authorized Representative through the contracted FMS vendor.

E. Attendant Support Management Plan (ASMP) means the documented plan described in 8.510.5, detailing management of Attendant support needs through CDASS.

F. Authorized Representative (AR) means an individual designated by the Client or the Client's legal guardian, if applicable, who has the judgment and ability to direct CDASS on a Client's behalf and meets the qualifications contained in 8.510.6 and 8.510.7.

G. Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6-106, C.R.S., and has a current provider participation agreement with the Department.

H. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual Client's functional eligibility for one or more Home and Community-based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the Client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and periodic reassessment of Client needs.

I. Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that empowers Clients to direct their care and services to assist them in accomplishing activities of daily living when included as a waiver benefit. CDASS benefits may include assistance with health maintenance, personal care, and homemaker activities.

J. CDASS Certification Period Allocation means the funds determined by the Case Manager and made available by the Department for Attendant services for the date span the Client is approved to receive CDASS within the annual certification period.

K. CDASS Task Worksheet: A tool used by a Case Manager to indicate the number of hours of assistance a Client needs for each covered CDASS personal care services, homemaker services, and health maintenance activities.

L. CDASS Training means the required CDASS training and comprehensive assessment provided by the Training and Operations Vendor to a Client or Authorized Representative.

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

N. Family Member means any person related to the Client by blood, marriage, adoption, or common law as determined by a court of law.

O. Financial Eligibility means the Health First Colorado financial eligibility criteria based on Client income and resources.

P. Financial Management Services (FMS) vendor means an entity contracted with the Department and chosen by the Client or Authorized Representative to complete employment-related functions for CDASS Attendants and to track and report on individual Client CDASS Allocations.

Q. Fiscal/Employer Agent (F/EA) provides FMS by performing payroll and administrative functions for Clients receiving CDASS benefits. The F/EA pays Attendants for CDASS services and maintains workers' compensation policies on the Client-employer's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both Client-employer and Attendant-employee Social Security and Medicare taxes.

R. Functional Eligibility means the physical and cognitive functioning criteria a Client must meet to qualify for a Medicaid waiver program, as determined by the Department's functional eligibility assessment tool.

S. Home and Community-based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to Clients in community settings. These services are designed to help older persons and persons with disabilities to live in the community.

T. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and Operations Vendor or the FMS, and which includes documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language.

U. Licensed Medical Professional means the primary care provider of the Client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN), as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

V. Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the Client.

W. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web site, Client account statements, Case Manager contact, or FMS vendor contact.

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

Y. Training and Operations Vendor means the organization contracted by the Department to provide training and customer service for self-directed service delivery options to Clients, Authorized Representatives, and Case Managers.

8.510.2 ELIGIBILITY

8.510.2.A. To be eligible for the CDASS delivery option, the Client shall meet the following eligibility criteria:

1. Choose the CDASS delivery option.

2. Meet HCBS waiver functional and financial eligibility requirements.

3. Demonstrate a current need for covered Attendant support services.

4. Document a pattern of stable Client health indicating appropriateness for community-based services and a predictable pattern of CDASS Attendant support.

5. Provide a statement, at an interval determined by the Department, from the Client's primary care physician, physician assistant, or advanced practice nurse, attesting to the Client's ability to direct their care with sound judgment or a required AR with the ability to direct the care on the Client's behalf.

6. Complete all aspects of the ASMP and training and demonstrate the ability to direct care or have care directed by an AR.

    a. Client training obligations

        i. Clients and ARs who have received training through the Training and Operations Vendor in the past two years and have utilized CDASS in the previous six months may receive a modified training to restart CDASS following an episode of closure. The Case Manager will review the allocation and attendant management for the Client's previous service utilization and consult with the Department to determine whether full retraining is required, or an abbreviated training based on history of managing allocation and services is needed.

        ii. A Client who was terminated from CDASS due to a Medicaid financial eligibility denial that has been resolved may resume CDASS without attending training if they had received CDASS in the previous six months.

8.510.3 COVERED SERVICES

8.510.3.A. Covered services shall be for the benefit of only the Client and not for the benefit of other persons.

8.510.3.B. Services include:

1. Homemaker: General household activities provided by an Attendant in a Client's home to maintain a healthy and safe environment for the Client. Homemaker activities shall be provided only in the primary living space of the Client and multiple Attendants may not be reimbursed for duplicating homemaker tasks. Tasks may include the following activities or teaching the following activities:

    a. Housekeeping, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas;

    b. Meal preparation;

    c. Dishwashing;

d. Bed making;

e. Laundry;

f. Shopping for necessary items to meet basic household needs.

2. Personal Care: Services furnished to an eligible Client in the community or in the Client's home to meet the Client's physical, maintenance, and supportive needs. Personal care tasks may include:

a. Eating/feeding, which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;

b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask from or to the Client's face;

c. Preventive skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays, and/or solutions, and monitoring for skin changes.

d. Bladder/Bowel Care:

i) Assisting Client to and from the bathroom;

ii) Assistance with bed pans, urinals, and commodes;

iii) Changing incontinence clothing or pads;

iv) Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v) Emptying ostomy bags;

vi) Perineal care.

e. Personal hygiene:

i) Bathing, including washing and shampooing;

ii) Grooming;

iii) Shaving with an electric or safety razor;

iv) Combing and styling hair;

v) Filing and soaking nails;

vi) Basic oral hygiene and denture care.

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints; and the application of artificial limbs when the Client is able to assist or direct.

g. Transferring a Client when the Client has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the Client and Attendant are fully trained in the use of the equipment and the Client can direct and assist with the transfer.

h. Mobility assistance when the Client has the ability to reliably balance and bear weight or when the Client is independent with an assistive device.

i. Positioning when the Client is able to verbally or non-verbally identify when their position needs to be changed, including simple alignment in a bed, wheelchair, or other furniture.

j. Medication Reminders when the medications have been preselected by the Client, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders and:

   i) Medication minders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;

   ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the Client and opening the appropriately marked medication minder if the Client is unable to do so independently.

k. Cleaning and basic maintenance of durable medical equipment.

l. Protective oversight when the Client requires supervision to prevent or mitigate disability-related behaviors that may result in imminent harm to people or property.

m. Accompanying includes going with the Client, as indicated in the care plan, to medical appointments and errands, such as banking and household shopping. Accompanying the Client to provide one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands-on assistance when tasks cannot be completed without the support of the Attendant.

3. Health Maintenance Activities: Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible Client in the community or in the Client's home, which are necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out. Services may include:

a. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection and the Client is unable to apply creams, lotions, sprays, or medications independently due to illness, injury or disability. Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when directed by a Licensed Medical Professional.

b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing and trimming.

c. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:

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

   ii) In the presence of communicable disease;

   iii) When the Client is unable to participate in the task;

   iv) Oral suctioning is required;

   v) There is decreased oral sensitivity or hypersensitivity;

   vi) Client is at risk for choking and aspiration.

d. Dressing performed when health maintenance-level skin care or transfers are required in conjunction with the dressing, or:

   i) The Client is unable to assist or direct care;

   ii) Assistance with the application of prescribed anti-embolic or pressure stockings is required;

   iii) Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.

e. Feeding is considered a health maintenance task when the Client requires health maintenance-level skin care or dressing in conjunction with the task, or:

   i) Oral suctioning is needed on a stand-by or intermittent basis;

   ii) The Client is on a prescribed modified texture diet;

   iii) The Client has a physiological or neurogenic chewing or swallowing problem;

   iv) Syringe feeding or feeding using adaptive utensils is required;

   v) Oral feeding when the Client is unable to communicate verbally, non-verbally or through other means.

f. Exercise prescribed by a Licensed Medical Professional, including passive range of motion.

g. Transferring a Client when they are not able to perform transfers independently due to illness, injury or disability, or:

   i) The Client lacks the strength and stability to stand, maintain balance or bear weight reliably;

   ii) The Client has not been deemed independent with adaptive equipment or assistive devices by a Licensed Medical Professional;

   iii) The use of a mechanical lift is needed.

h. Bowel care performed when health maintenance-level skin care or transfers are required in conjunction with the bowel care, or:

i) The Client is unable to assist or direct care;

ii) Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;

iii) Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.

i. Bladder care performed when health maintenance-level skin care or transfers are required in conjunction with bladder care, or;

i) The Client is unable to assist or direct care;

ii) Care of external, indwelling and suprapubic catheters;

iii) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.

j. Medical management as directed by a Licensed Medical Professional to routinely monitor a documented health condition, including but not limited to: blood pressures, pulses, respiratory rate, blood sugars, oxygen saturations, intravenous or intramuscular injections.

k. Respiratory care:

i) Postural drainage;

ii) Cupping;

iii) Adjusting oxygen flow within established parameters;

iv) Suctioning mouth and/or nose;

v) Nebulizers;

vi) Ventilator and tracheostomy care;

vii) Assistance with set-up and use of respiratory equipment.

l. Bathing assistance is considered a health maintenance task when the Client requires health maintenance-level skin care, transfers or dressing in conjunction with bathing.

m. Medication assistance, which may include setup, handling and administering medications.

n. Accompanying includes going with the Client, as necessary according to the care plan, to medical appointments, and errands such as banking and household

shopping. Accompanying the Client to provide one or more health maintenance tasks as needed during the trip. Attendant may assist with communication, documentation, verbal prompting and/or hands on assistance when the task cannot be completed without the support of the Attendant.

o. Mobility assistance is considered a health maintenance task when health maintenance-level transfers are required in conjunction with the mobility assistance, or:

i) The Client is unable to assist or direct care;

ii) When hands-on assistance is required for safe ambulation and the Client is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or

iii) The Client has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional

p. Positioning includes moving the Client from the starting position to a new position while maintaining proper body alignment, support to a Client's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;

i) The Client is unable to assist or direct care, or

ii) The Client is unable to complete task independently

4. Services that may be directed by the Client or their selected AR under the Home and Community-based Supported Living Services (HCBS-SLS) waiver are as follows:

a. Homemaker services, as defined at Section 8.500.94.

b. Personal care services, as defined at Section 8.500.94.

c. Health maintenance activities as defined at Section 8.500.94.

8.510.4 EXCLUDED SERVICES

8.510.4.A. CDASS Attendants are not authorized to perform services and payment is prohibited:

1. While Client is admitted to a nursing facility, hospital, a long-term care facility or incarcerated;

2. Following the death of Client;

3. That are duplicative or overlapping. The Attendant cannot be reimbursed to perform tasks at the time a Client is concurrently receiving a waiver service in which the provider is required to perform the tasks in conjunction with the service being rendered;

Companionship is not a covered CDASS service.

8.510.5 ATTENDANT SUPPORT MANAGEMENT PLAN

8.510.5.A. The Client/AR shall develop a written ASMP after completion of training but prior to the start date of services, which shall be reviewed by the Training and Operations Vendor and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date to the FMS. The ASMP is required following initial training and retraining and shall be modified when there is a change in the Client's needs. The plan shall describe the Client's:

1. Needed Attendant support;

2. Plans for locating and hiring Attendants;

3. Plans for handling emergencies;

4. Assurances and plans regarding direction of CDASS Services, as described at 8.510.3 and 8.510.6, if applicable.

5. Plans for budget management within the Client's Allocation.

6. Designation of an AR, if applicable.

7. Designation of regular and back-up employees proposed or approved for hire.

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

8.510.6 CLIENT/AR RESPONSIBILITES

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

1. Complete training provided by the Training and Operations Vendor. Clients who cannot complete trainings shall designate an AR.

2. Develop an ASMP at initial enrollment and at time of an Allocation change based on the Client's needs.

3. Determine wages for each Attendant not to exceed the rate established by the Department. Wages shall be established in accordance with Colorado Department of Labor and Employment standards including, but not limited to, minimum wage and overtime requirements. Attendant wages may not be below the state and federal requirements at the location where the service is provided.

4. Determine the required qualifications for Attendants.

5. Recruit, hire and manage Attendants.

6. Complete employment reference checks on Attendants.

7. Train Attendants to meet the Client's needs. When necessary to meet the goals of the ASMP, the Client/AR shall verify that each Attendant has been or will be trained in all necessary health maintenance activities prior to performance by the Attendant.

8. Terminate Attendants when necessary, including when an Attendant is not meeting the Client's needs.

9. Operate as the Attendant's legal employer of record.

10. Complete necessary employment-related functions through the FMS vendor, including hiring and termination of Attendants and employer-related paperwork necessary to obtain an employer tax ID.

11. Ensure all Attendant employment documents have been completed and accepted by the FMS vendor prior to beginning Attendant services.

12. Follow all relevant laws and regulations applicable to the supervision of Attendants.

13. Explain the role of the FMS vendor to the Attendant.

14. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation. Services that exceed the Client's monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the Client or AR for reimbursement through the FMS vendor.

15. Authorize Attendant to perform services allowed through CDASS.

16. 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.

17. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement.

18. Authorize the FMS vendor to make any changes in the Attendant wages.

19. Understand that misrepresentations or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. Client/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS vendor.

20. Completing and managing all paperwork and maintaining employment records.

21. Select an FMS vendor upon enrollment into CDASS.

8.510.6.B. Client/AR responsibilities for Verification:

1. Sign and return a responsibilities acknowledgement form for activities listed in 8.510.6 to the Case Manager.

8.510.6.C. Clients utilizing CDASS have the following rights:

1. Right to receive training on managing CDASS.

2. Right to receive program materials in accessible format.

3. Right to receive advance Notification of changes to CDASS.

4. Right to participate in Department-sponsored opportunities for input.

5. Clients using CDASS have the right to transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.

6. A Client/AR may request a reassessment if the Client's level of service needs have changed.

7. A Client/AR may revise the ASMP at any time with Case Manager approval.

8.510.7 AUTHORIZED REPRESENTATIVES (AR)

8.510.7.A. A person who has been designated as an AR shall submit an AR designation affidavit attesting that he or she:

1. Is least eighteen years of age;

2. Has known the eligible person for at least two years;

3. Has not been convicted of any crime involving exploitation, abuse, or assault on another person; and

4. Does not have a mental, emotional, or physical condition that could result in harm to the Client.

8.510.7.B. CDASS Clients who require an AR may not serve as an AR for another CDASS Client.

8.510.7.C. An AR shall not receive reimbursement for CDASS AR services and shall not be reimbursed as an Attendant for the Client they represent.

8.510.7.D. An AR must comply with all requirements contained in 8.510.6.

8.510.8 ATTENDANTS

8.510.8.A. Attendants shall be at least ~~18~~ 16 years of age and demonstrate competency in caring for the Client to the satisfaction of the Client/AR.

1. Minor attendants will not be permitted to operate floor-based vertical powered patient/resident lift devices, ceiling-mounted vertical powered patient/resident lift devices, and powered sit-to-stand patient/resident lift devices (lifting devices).

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

8.510.8.C. An AR shall not be employed as an Attendant for the same Client for whom they are an AR.

8.510.8.D. Attendants must be able to perform the tasks on the ASMP they are being reimbursed for and the Client must have adequate Attendants to assure compliance with all tasks on the ASMP.

8.510.8.E. Attendant timesheets submitted for approval must be accurate and reflect time worked.

8.510.8.F. Attendants shall not misrepresent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse.

8.510.8.G. Attendants shall not have had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

8.510.8.H. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the Client/AR not to exceed the amount established by the Department. The FMS vendor shall make all payments from the Client's Allocation under the direction of the Client/AR within the limits established by the Department.

8.510.8.I. Attendants are not eligible for hire if their background check identifies a conviction of a crime that the Department has identified as a barrier crime that can create a health and safety risk to the Client. A list of barrier crimes is available through the Training and Operations Vendor and FMS vendors.

8.510.8.J. Attendants may not participate in training provided by the Training and Operations Vendor. Clients may request to have their Attendant, or a person of their choice, present to assist them during the training based on their personal assistance needs. Attendants may not be present during the budgeting portion of the training.

8.510.9 FINANCIAL MANAGEMENT SERVICES (FMS)

8.510.9.A. FMS vendors shall be responsible for the following tasks:

1. Collect and process timesheets submitted by attendants within agreed-upon timeframes as identified in FMS vendor materials and websites.

2. Conduct payroll functions, including withholding employment-related taxes such as workers' compensation insurance, unemployment benefits, withholding of all federal and state taxes, and compliance with federal and state laws regarding overtime pay and minimum wage.

3. Distribute paychecks in accordance with agreements made with Client/AR and timelines established by the Colorado Department of Labor and Employment.

4. Submit authorized claims for CDASS provided to an eligible Client.

5. Verify Attendants' citizenship status and maintain copies of I-9 documents.

6. Track and report utilization of Client allocations.

7. Comply with Department regulations and the FMS vendor contract with the Department.

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

8.510.10 SELECTION OF FMS VENDORS

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

8.510.10.B The Client/AR may select a new FMS vendor during the designated open enrollment periods. The Client/AR shall remain with the selected FMS vendor until the transition to the new FMS vendor is completed.

8.510.11 START OF SERVICES

8.510.11.A. The CDASS start date shall not occur until all of the requirements contained in 8.510.2, 8.510.5, 8.510.6 and 8.510.8 have been met.

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

8.510.11.C. The FMS vendor shall process the Attendant's employment packet within the Department's prescribed timeframe and ensure the Client has a minimum of two approved Attendants prior to starting CDASS. The Client must maintain employment relationships with two Attendants while participating in CDASS.

8.510.11.D. The FMS vendor will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS vendor provides the Client/AR with employee numbers and confirms Attendants' employment status.

8.510.11.E. If a Client is transitioning from a hospital, nursing facility, or HCBS agency services, the Case Manager shall coordinate with the discharge coordinator to ensure that the Client's discharge date and CDASS start date correspond.

8.510.12 SERVICE SUBSTITUTION

8.510.12.A. Once a start date has been established for CDASS, the Case Manager shall establish an end date and discontinue the Client from any other Medicaid-funded Attendant support including Long-term Home Health, homemaker and personal care services effective as of the start date of CDASS.

8.510.12.B. Case Managers shall not authorize PARs with concurrent payments for CDASS and other waiver service delivery options for Personal Care services, Homemaker services, and Health Maintenance Activities for the same Client.

8.510.12.C. Clients may receive up to sixty days of Medicaid Acute Home Health services directly following acute episodes as defined by 8.523.11.K.1. CDASS service plans shall be modified to ensure no duplication of services.

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

8.510.13 FAILURE TO MEET CLIENT/AR RESPONSIBILITIES

8.510.13.A. If a Client/AR fails to meet their CDASS responsibilities, the Client may be terminated from CDASS. Prior to a Client being terminated from CDASS the following steps shall be taken:

1. Mandatory re-training conducted by the contracted Training and Operations Vendor.

2. Required designation of an AR if one is not in place, or mandatory re-designation of an AR if one has already been assigned.

8.510.13.B. Actions requiring retraining, or appointment or change of an AR include any of the following:

1. The Client/AR does not comply with CDASS program requirements including service exclusions.

2. The Client/AR demonstrates an inability to manage Attendant support.

3. The Client no longer meets program eligibility criteria due to deterioration in physical or cognitive health as determined by the Client's physician, physician assistant, or advance practice nurse.

4. The Client/AR spends the monthly Allocation in a manner causing premature depletion of funds without authorization from the Case Manager or reserved funds. The Case Manager will follow the service utilization protocol.

5. The Client/AR exhibits Inappropriate Behavior as defined at 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor, or the FMS vendor.

6. The Client/AR authorizes the Attendant to perform services while the Client is in a nursing facility, hospital, a long-term care facility or while incarcerated.

8.510.14 IMMEDIATE INVOLUNTARY TERMINATION

8.510.14.A. Clients may be involuntarily terminated immediately from CDASS for the following reasons:

1. A Client no longer meets program criteria due to deterioration in physical or cognitive health AND the Client refuses to designate an AR to direct services.

2. The Client/AR demonstrates a consistent pattern of overspending their monthly Allocation leading to the premature depletion of funds AND the Case Manager has determined that attempts using the service utilization protocol to assist the Client/AR to resolve the overspending have failed.

3. The Client/AR exhibits Inappropriate Behavior as defined at 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor or the FMS vendor, and the Department has determined that the Training and Operations Vendor has made attempts to assist the Client/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

4. Client/AR authorized the Attendant to perform services for a person other than the Client, authorized services not available in CDASS, or allowed services to be performed while the Client is in a hospital, nursing facility, a long-term care facility or while incarcerated and the Department has determined the Training and Operations Vendor has made adequate attempts to assist the Client/AR in managing appropriate services through retraining.

5. Intentional submission of fraudulent CDASS documents or information to Case Managers, the Training and Operations Vendor, the Department, or the FMS vendor.

6. Instances of proven fraud, abuse, and/or theft in connection with the Colorado Medical Assistance program.

7. Client/AR fails to complete retraining, appoint an AR, or remediate CDASS management per 8.510.13.A.

8.510.15 ENDING THE CDASS DELIVERY OPTION

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

8.510.15.B. In the event of discontinuation of or termination from CDASS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the Client or AR with the reasons for termination, information about the Client's rights to fair hearing, and appeal procedures. Once notice has been given for termination, the Client or AR may contact the Case Manager for assistance in obtaining other home care services or additional benefits, if needed.

2. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS and begin alternate care services. Exceptions may be made to increase or decrease the thirty (30) day advance notice requirement when the Department has documented that there is danger to the Client. The Case Manager shall notify the FMS vendor of the date on which the Client is being terminated from CDASS.

8.510.15.C. Clients who are involuntarily terminated pursuant to 8.510.14.A 2., 8.510.14.A.4., 8.510.14.A.5, 8.510.14.A.6., and 8.510.14.A.7. may not be re-enrolled in CDASS as a service delivery option.

8.510.15.D. Clients who are involuntary terminated pursuant to 8.510.14.A.1. are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at 8.510.2.A.5. The Client or AR must have successfully completed CDASS training prior to enrollment in CDASS.

8.510.15.E. Clients who are involuntary terminated pursuant to 8.510.14.A.3 are eligible for enrollment in CDASS with the appointment of an AR. The Client must meet all CDASS eligibility requirements with the AR completing CDASS training prior to enrollment in CDASS.

8.510.16 CASE MANAGEMENT FUNCTIONS

8.510.16.A. The Case Manager shall review and approve the ASMP completed by the Client/AR. The Case Manager shall notify the Client/AR of ASMP approval and establish a service period and Allocation.

8.510.16.B. If the Case Manager determines that the ASMP is inadequate to meet the Client's CDASS needs, the Case Manager shall work with the Client/AR to complete a fully developed ASMP.

8.510.16.C. The Case Manager shall calculate the Allocation for each Client who chooses CDASS as follows:

1. Calculate the number of personal care, homemaker, and health maintenance activities hours needed on a monthly basis using the Department's prescribed method. The needs determined for the Allocation should reflect the needs in the Department-approved assessment tool and the service plan. The Case Manager shall use the Department's established rate for personal care, homemaker, and health maintenance activities to determine the Client's Allocation.

2. The Allocation should be determined using the Department's prescribed method at the Client's initial CDASS enrollment and at reassessment. Service authorization will align

with the Client's need for services and adhere to all service authorization requirements and limitations established by the Client's waiver program.

3. Allocations that exceed care in an institutional setting cannot be authorized by the Case Manager without Department approval. The Case Manager will follow the Department's over-cost containment process and receive authorization prior to authorizing a start date for Attendant services.

8.510.16.D. Prior to training or when an Allocation changes, the Case Manager shall provide written Notification of the Allocation to the Client and the AR, if applicable.

8.510.16.E. A Client or AR who believes the Client needs a change in Attendant support, may request the Case Manager to perform a review of the CDASS Task Worksheet and Allocation for services. Review should be completed within five (5) business days.

1. If the review indicates that a change in Attendant support is justified, the following actions will be taken:

   a. The Case Manager shall provide notice of the Allocation change to the Client/AR utilizing a long-term care notice of action form within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

   b. The Case Manager shall complete a PAR revision indicating the increase in CDASS Allocation using the Department's Medicaid Management Information System and FMS vendor system. PAR revisions shall be completed within five (5) business days of the Allocation determination.

   c. The Client/AR shall amend the ASMP and submit it to the Case Manager.

2. The Training and Operations Vendor is available to facilitate a review of services and provide mediation when there is a disagreement in the services authorized on the CDASS Task Worksheet.

3. The Case Manager will notify the Client of CDASS Allocation approval or disapproval by providing a long-term care notice of action form to Clients within ten (10) business days regarding their appeal rights in accordance with Section 8.057, et seq.

8.510.16.F. In approving an increase in the Client's Allocation, the Case Manager shall consider all of the following:

1. Any deterioration in the Client's functioning or change in availability of natural supports, meaning assistance provided to the Client without the requirement or expectation of compensation.

2. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services.

3. The appropriate use and application of funds for CDASS services.

8.510.16.G. In reducing a Client's Allocation, the Case Manager shall consider:

1. Improvement of functional condition or changes in the available natural supports.

2. Inaccuracies or misrepresentation in the Client's previously reported condition or need for service.

3. The appropriate use and application of funds for CDASS services.

8.510.16.H. Case Managers shall cease payments for all existing Medicaid-funded personal care, homemaker, health maintenance activities and/or Long-Term Home Health as defined under the Home Health Program at Section §8.520 et seq. as of the Client's CDASS start date.

8.510.16.I. For effective coordination, monitoring and evaluation of Clients receiving CDASS, the Case Manager shall:

1. Contact the CDASS Client/AR once a month during the first three months to assess their CDASS management, their satisfaction with Attendants, and the quality of services received. Case Managers may refer Clients/ARs to the FMS vendor for assistance with payroll and to the Training and Operations Vendor for training needs, budgeting, and supports.

2. Contact the Client/AR quarterly after the first three months to assess their implementation of Attendant services, CDASS management issues, quality of care, Allocation expenditures, and general satisfaction.

3. Contact the Client/AR when a change in AR occurs and contact the Client/AR once a month for three months after the change takes place.

4. Review monthly FMS vendor reports to monitor Allocation spending patterns and service utilization to ensure appropriate budgeting and follow up with the Client/AR when discrepancies occur.

5. Utilize Department overspending protocol when needed to assist CDASS Client/AR.

6. Follow protocols established by the Department for case management activities.

8.510.16.J. Reassessment: The Case Manager will follow in-person and phone contact requirements based on the Client's waiver program. Contacts shall include a review of care needs, the ASMP, and documentation from the physician, physician assistant, or advance practice nurse stating the Client's ability to direct care.

8.510.16.K. Case Managers shall participate in training and consulting opportunities with the Department's contracted Training and Operations Vendor.

8.510.17 ATTENDANT REIMBURSEMENT

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

8.510.17.B. Attendant timesheets that exceed the Client's monthly CDASS Allocation by 30% or more are not allowed and cannot be authorized by the Client or AR for reimbursement through the FMS vendor.

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

8.510.17.D. Allocations that exceed the cost of providing services in a facility cannot be authorized by the Case Manager without Department approval.

8.510.18 REIMBURSEMENT TO FAMILY MEMBERS

8.510.18.A. Family Members/legal guardians may be employed by the Client/AR to provide CDASS, subject to the conditions below.

8.510.18.B. The family member or legal guardian shall be employed by the Client/AR and be supervised by the Client/AR.

8.510.18.C. The Family Member and/or legal guardian being reimbursed as a personal care, homemaker, and/or health maintenance activities Attendant shall be reimbursed at an hourly rate with the following restrictions:

1. A Family Member and/or legal guardian shall not be reimbursed for more than forty (40) hours of CDASS in a seven-day period from 12:00 am on Sunday to 11:59 pm on Saturday.

2. Family Member wages shall be commensurate with the level of skill required for the task and should not deviate from that of a non-Family Member Attendant unless there is evidence of that the Family Member has a higher level of skill.

3. A member of the Client's household may only be paid to furnish extraordinary care as determined by the Case Manager. Extraordinary care is determined by assessing whether the care to be provided exceeds the range of care that a Family Member would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the Client and avoid institutionalization. Extraordinary care shall be documented on the service plan.

8.510.18.D. A Client/AR who chooses a Family Member as a care provider, shall document the choice on the ASMP.

8.552 IN-HOME SUPPORT SERVICES

8.552.1 DEFINITIONS

A. Assessment means a comprehensive evaluation with the client seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department prescribed tool to complete assessments.

B. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS. A family member, including a spouse, may be an Attendant.

C. Authorized Representative means an individual designated by the client, or by the parent or guardian of the client, if appropriate, who has the judgment and ability to assist the client in

acquiring and receiving services under Title 25.5, Article 6, Part 12, C.R.S. The authorized representative shall not be the eligible person's service provider.

D. Care Plan means a written plan of care developed between the client or the client's Authorized Representative, IHSS Agency and Case Management Agency that is authorized by the Case Manager.

E. Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6- 106, C.R.S., and has a current provider participation agreement with the Department.

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

G. Extraordinary Care means a service which exceeds the range of care a Family Member would ordinarily perform in a household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the client and avoid institutionalization.

H. Family Member means any person related to the client by blood, marriage, adoption, or common law as determined by a court of law.

I. Health Maintenance Activities means those routine and repetitive skilled health-related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if they were physically able, or that would be carried out by Family Members or friends if they were available. These activities include skilled tasks typically performed by a Certified Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment and judgement of a licensed nurse.

J. Homemaker Services means general household activities provided by an Attendant in the client's primary living space to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

K. Inappropriate Behavior means documented verbal, sexual or physical threats or abuse committed by the client or Authorized Representative toward Attendants, Case Managers, or the IHSS Agency.

L. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of institutions. These services include but are not limited to: information and referral services, independent living skills training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and institutions to home and community-based living, or upon leaving secondary education.

M. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the client or client's Authorized Representative, including Health Maintenance Activities and support for activities of daily living or instrumental activities of daily living, Personal Care services and Homemaker services.

N. In-Home Support Services (IHSS) Agency means an agency that is certified by the Colorado Department of Public Health and Environment, enrolled in the Medicaid program and provides Independent Living Core Services.

O. Licensed Health Care Professional means a state-licensed Registered Nurse (RN) who contracts with or is employed by the IHSS Agency,

P. Licensed Medical Professional means the primary care provider of the client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN) as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

Q. Personal Care means services which are furnished to an eligible client meet the client's physical, maintenance and supportive needs, when those services are not skilled Personal Care, do not require the supervision of a nurse, and do not require physician's orders.

R. Prior Authorization Request (PAR) means the Department prescribed process used to authorize HCBS waiver services before they are provided to the client, pursuant to Section 8.485.90.

8.552.2 ELIGIBILITY

8.552.2.A. To be eligible for IHSS the client shall meet the following eligibility criteria:

1. Be enrolled in a Medicaid program approved to offer IHSS.

2. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition stating that the client has sound judgment and the ability to self-direct care. If the client is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.

3. Clients who elect or are required to have an Authorized Representative must appoint an Authorized Representative who has the judgment and ability to assist the client in acquiring and using services, or

    a. Obtain assistance from an IHSS Agency that is able and willing to support the client as necessary to participate in IHSS.

4. Demonstrate a current need for covered Attendant support services.

8.552.2.B. IHSS eligibility for a client will end if:

1. The client is no longer enrolled in a Medicaid program approved to offer IHSS.

2. The client’s medical condition deteriorates causing an unsafe situation for the client or the Attendant as determined by the client's Licensed Medical Professional.

3. The client refuses to designate an Authorized Representative or receive assistance from an IHSS Agency when the client is unable to direct their own care as documented by the client's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.

4. The client provides false information or false records.

5. The client no longer demonstrates a current need for Attendant support services.

8.552.3 COVERED SERVICES

8.552.3.A. Services are for the benefit of the client. Services for the benefit of other persons are not reimbursable.

8.552.3.B. Services available for eligible adults:

1. Homemaker

2. Personal Care

3. Health Maintenance Activities.

8.552.3.C. Services available for eligible children:

1. Health Maintenance Activities.

8.552.3.D. Service Inclusions:

1. Homemaker:

   a. Routine housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas;

   b. Meal preparation;

   c. Dishwashing;

   d. Bed making;

   e. Laundry;

   f. Shopping for necessary items to meet basic household needs.

2. Personal Care:

   a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;

   b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask to or from the client's face;

   c. Preventative skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays and/or solutions, and monitoring for skin changes.

   d. Bladder/Bowel Care:

      i) Assisting client to and from the bathroom;

ii) Assistance with bed pans, urinals, and commodes;

iii) Changing incontinence clothing or pads;

iv) Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v) Emptying ostomy bags;

vi) Perineal care.

e. Personal hygiene:

i) Bathing including washing, shampooing;

ii) Grooming;

iii) Shaving with an electric or safety razor;

iv) Combing and styling hair;

v) Filing and soaking nails;

vi) Basic oral hygiene and denture care.

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints, and the application of artificial limbs when the client is able to assist or direct.

g. Transferring a client when the client has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the client and Attendant are fully trained in the use of the equipment and the client can direct and assist with the transfer.

h. Mobility assistance when the client has the ability to reliably balance and bear weight or when the client is independent with an assistive device.

i. Positioning when the client is able to verbally or non-verbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.

j. Medication Reminders when medications have been preselected by the client, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:

i) Medication minders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;

ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable to do so independently.

k. Cleaning and basic maintenance of durable medical equipment.

l. Protective oversight when the client requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property.

m. Accompanying includes going with the client, as indicated on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the client may include providing one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the attendant.

3. Health Maintenance Activities:

a. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection, and the client is unable to apply prescription creams, lotions, or sprays independently due to illness, injury or disability. Skin care may include wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when directed by a Licensed Medical Professional.

b. Hair care including shampooing, conditioning, drying, and combing when performed in conjunction with health maintenance level bathing, dressing, or skin care. Hair care may be performed when:

i) Client is unable to complete task independently;

ii) Application of a prescribed shampoo/conditioner which has been dispensed by a pharmacy; or

iii) Client has open wound(s) or neck stoma(s).

c. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing and trimming.

d. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:

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

ii) In the presence of communicable disease;

iii) When the client is unable to participate in the task;

iv) Oral suctioning is required;

v) There is decreased oral sensitivity or hypersensitivity;

vi) Client is at risk for choking and aspiration.

e. Shaving performed when health maintenance level skin care is required in conjunction with the shaving, or:

i. The client has a medical condition involving peripheral circulatory problems;

ii. The client has a medical condition involving loss of sensation;

iii. The client has an illness or takes medications that are associated with a high risk for bleeding;

iv. The client has broken skin at/near shaving site or a chronic active skin condition.

f. Dressing performed when health maintenance level skin care or transfers are required in conjunction with the dressing, or;

i. The client is unable to assist or direct care;

ii. Assistance with the application of prescribed anti-embolic or pressure stockings is required;

iii. Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.

g. Feeding is considered a health maintenance task when the client requires health maintenance level skin care or dressing in conjunction with the task, or:

i) Oral suctioning is needed on a stand-by or intermittent basis;

ii) The client is on a prescribed modified texture diet;

iii) The client has a physiological or neurogenic chewing or swallowing problem;

iv) Syringe feeding or feeding using adaptive utensils is required;

v) Oral feeding when the client is unable to communicate verbally, non-verbally or through other means.

h. Exercise including passive range of motion. Exercises must be specific to the client's documented medical condition and require hands on assistance to complete.

i. Transferring a client when they are not able to perform transfers due to illness, injury or disability, or:

i) The client lacks the strength and stability to stand, maintain balance or bear weight reliably;

ii) The client has not been deemed independent with adaptive equipment or assistive devices by a Licensed Medical Professional;

iii) The use of a mechanical lift is needed.

j. Bowel care performed when health maintenance level skin care or transfers are required in conjunction with the bowel care, or:

i) The client is unable to assist or direct care;

ii) Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;

iii) Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.

k. Bladder care performed when health maintenance level skin care or transfers are required in conjunction with bladder care, or;

i) The client is unable to assist or direct care;

ii) Care of external, indwelling and suprapubic catheters;

iii) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.

l. Medical management as directed by a Licensed Medical Professional to routinely monitor a documented health condition, including but not limited to: blood pressures, pulses, respiratory rate, blood sugars, oxygen saturations, intravenous or intramuscular injections

m. Respiratory care:

i) Postural drainage

ii) Cupping

iii) Adjusting oxygen flow within established parameters

iv) Suctioning of mouth and nose

v) Nebulizers

vi) Ventilator and tracheostomy care

vii) Assistance with set-up and use of respiratory equipment

n. Bathing is considered a health maintenance task when the client requires health maintenance level skin care, transfers or dressing in conjunction with bathing.

o. Medication Assistance, which may include setup, handling and assisting the client with the administration of medications. The IHSS Agency's Licensed Health Care Professional must validate Attendant skills for medication administration and ensure that the completion of task does not require clinical judgement or assessment skills.

p. Accompanying includes going with the client, as necessary on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the client also may include providing one or more health maintenance tasks as needed during the trip. Attendant may assist with communication, documentation, verbal prompting and/or hands on assistance when the task cannot be completed without the support of the Attendant.

q. Mobility assistance is considered a health maintenance task when health maintenance level transfers are required in conjunction with the mobility assistance, or:

i) The client is unable to assist or direct care;

ii) When hands-on assistance is required for safe ambulation and the client is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or

iii) the client has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional.

r. Positioning includes moving the client from the starting position to a new position while maintaining proper body alignment, support to a client's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;

i) the client is unable to assist or direct care, or

ii) the client is unable to complete task independently.

8.552.4 CLIENT AND AUTHORIZED REPRESENTATIVE PARTICIPATION AND SELF-DIRECTION

8.552.4.A. A client or their Authorized Representative may self-direct the following aspects of service delivery:

1. Present a person(s) of their own choosing to the IHSS Agency as a potential Attendant. The client must have adequate Attendants to assure compliance with all tasks in the Care Plan.

2. Train Attendant(s) to meet their needs.

3. Dismiss Attendants who are not meeting their needs.

4. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.

5. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the client's Licensed Medical Professional.

6. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.

7. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.

8. Request a reassessment, as described at Section 8.393.2.D, if level of care or service needs have changed.

8.552.4.B. An Authorized Representative is not allowed to be reimbursed for IHSS Attendant services for the client they represent.

8.552.4.C. If the client is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:

1. Must be at least 18 years of age.

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 must be a licensed home care agency. The IHSS Agency shall be in compliance with all requirements of their certification and licensure, in addition to requirements outlined at Section 8.487.

8.552.5.B. The provider agreement for an IHSS Agency may be terminated, denied, or non-renewed pursuant to Section 8.076.5.

8.552.5.C. Administrators or managers as defined at 6 CCR 1011-1 Chapter 26 shall satisfactorily complete the Department authorized training on IHSS rules and regulations prior to Medicaid certification and annually thereafter.

8.552.6 IHSS AGENCY RESPONSIBILITIES

8.552.6.A. The IHSS Agency shall assure and document that all clients are provided the following:

1. Independent Living Core Services

   a. An IHSS Agency must provide a list of the full scope of Independent Living Core Services provided by the agency to each client on an annual basis. The IHSS Agency must keep a record of each client's choice to utilize or refuse these services, and document services provided

2. Attendant training, oversight and supervision by a licensed health care professional. .

3. The IHSS agency shall provide 24-hour back-up service for scheduled visits to clients at any time an Attendant is not available. At the time the Care Plan is developed the IHSS Agency shall ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.

8.552.6.B. The IHSS Agency shall adhere to the following:

1. If the IHSS Agency admits clients with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the agency or have other effective back-up plans to ensure the needs of the client are met.

2. The IHSS Agency shall only accept clients for care or services based on a reasonable assurance that the needs of the client can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.

    a. There shall be documentation in the Care Plan or client record of the agreed upon days and times of services to be provided based upon the client's needs that is updated at least annually.

3. If an IHSS Agency receives a referral of a client who requires care or services that are not available at the time of referral, the IHSS Agency shall advise the client or their Authorized Representative and the Case Manager of that fact.

    a. The IHSS Agency shall only admit the client if the client or their Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.

4. The IHSS Agency shall ensure orientation is provided to clients or Authorized Representatives who are new to IHSS or request re-orientation through The Department's prescribed process. Orientation shall include instruction in the philosophy, policies and procedures of IHSS and information concerning client rights and responsibilities.

5. The IHSS Agency will keep written service notes documenting the services provided at each visit.

8.552.6.C. The IHSS Agency is the legal employer of a client's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by The Department.

8.552.6.D. The IHSS Agency shall assist all clients in interviewing and selecting an Attendant when requested and maintain documentation of the IHSS Agency's assistance and/or the client's refusal of such assistance.

8.552.6.E. The IHSS Agency will complete an intake assessment following referral from the Case Manager. The IHSS Agency will develop a Care Plan in coordination with the Case Manager and client. Any proposed services outlined in the Care Plan that may result in an increase in authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to start of services.

8.552.6.F. The IHSS Agency shall ensure that a current Care Plan is in the client's record, and that Care Plans are updated with the client at least annually or more frequently in the event of a client's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.

1. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope and duration of each service to be provided to the client for each day and visit. The Care Plan shall be signed by the client or the client's Authorized Representative and the IHSS Agency.

    a. Secondary or contiguous tasks must be outlined on the care plan as described in Section 8.552.8.F.

2. In the event of the observation of new symptoms or worsening condition that may impair the client's ability to direct their care, the IHSS Agency, in consultation with the client or

their Authorized Representative and Case Manager, shall contact the client's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the client's revised Care Plan, with the client and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval.

8.552.6.G. The IHSS Agency's Licensed Health Care Professional is responsible for the following activities:

1. Administer a skills validation test for Attendants who will perform Health Maintenance Activities. Skills validation for all assigned tasks must be completed prior to service delivery unless postponed by the client or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS in the client's file. In no event shall the skills validation be postponed for more than thirty (30) days after services begin to prevent interruption in services.

2. Verify and document Attendant skills and competency to perform IHSS and basic client safety procedures.

3. Counsel Attendants and staff on difficult cases and potentially dangerous situations.

4. Consult with the client, Authorized Representative or Attendant in the event a medical issue arises.

5. Investigate complaints and critical incidents within ten (10) calendar days as defined in Section 8.487.15.

6. Verify the Attendant follows all tasks set forth in the Care Plan.

7. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the client, their Authorized Representative, or the Case Manager.

8. Provide in-home supervision for the client as recommended by their Licensed Medical Professional and as agreed upon by the client or their Authorized Representative.

8.552.6.H. At the time of enrollment and following any change of condition, the IHSS Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the client record.

1. The IHSS Agency shall collaborate with the client or client's Authorized Representative to determine the level of supervision provided by the IHSS Agency's Licensed Health Care Professional beyond the requirements set forth at Section 25.5-6-1203, C.R.S.

2. The client may decline recommendations by the Licensed Medical Professional for in-home supervision. The IHSS Agency must document this choice in the client record and notify the Case Manager. The IHSS Agency and their Licensed Health Care Professional, Case Manager, and client or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

8.552.6.I. The IHSS Agency shall assure and document that all Attendants have received training in the delivery of IHSS prior to the start of services. Attendant training shall include:

1. Development of interpersonal skills focused on addressing the needs of persons with disabilities.

2. Overview of IHSS as a service-delivery option of consumer direction.

3. Instruction on basic first aid administration.

4. Instruction on safety and emergency procedures.

5. Instruction on infection control techniques, including universal precautions.

6. Mandatory reporting and critical incident reporting procedures.

7. Skills validation test for unskilled tasks assigned on the care plan.

8.552.6.J. The IHSS Agency shall allow the client or Authorized Representative to provide individualized Attendant training that is specific to their own needs and preferences.

8.552.6.K. With the support of the IHSS Agency, Attendants must adhere to the following:

1. Must be at least ~~18~~ 16 years of age and demonstrate competency in caring for the client to the satisfaction of the client or Authorized Representative.

   a. Minor attendants will not be permitted to operate floor-based vertical powered patient/resident lift devices, ceiling-mounted vertical powered patient/resident lift devices, and powered sit-to-stand patient/resident lift devices (lifting devices).

2. May be a Family Member subject to the reimbursement and service limitations in Section 8.552.8.

3. Must be able to perform the assigned tasks on the Care Plan.

4. Shall not, in exercising their duties as an IHSS Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse as defined in Section 25.5-6-1203, C.R.S.

5. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.

8.552.6.L. The IHSS Agency shall provide functional skills training to assist clients and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

8.552.7 CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.552.7.A. The Case Manager shall provide information and resources about IHSS to eligible clients, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.

8.552.7.B. The Case Manager will initiate a referral to the IHSS Agency of the client or Authorized Representative's choice, including an outline of approved services as determined by the Case Manager's most recent assessment. The referral must include the Physician Attestation, assessment information, and other pertinent documentation to support the development of the Care Plan.

8.552.7.C. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:

1. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.

2. 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 within five business days of receipt to ensure there is no disruption or delay in the start of services.

2. Ensure all required information is in the client's Care Plan and that services are appropriate given the client's medical or functional condition. If needed, request additional information from the client, their Authorized Representative, the IHSS Agency, or Licensed Medical Professional regarding services requested.

3. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.

4. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the client's eligible benefits.

5. Collaborate with the client or their Authorized Representative and the IHSS Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.

6. Authorize cost-effective and non-duplicative services via the PAR. Provide a copy of the PAR to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.

7. Work collaboratively with the IHSS Agency, client, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.

    a. Case Manager will complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the client's rights to fair hearing, and appeal procedures.

8.552.7.E. The Case Manager shall ensure cost-effectiveness and non-duplication of services by:

1. Documenting the discontinuation of previously authorized agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by IHSS.

2. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.

a. A client may receive non-duplicative services from multiple Attendants or agencies if appropriate for the client's level of care and documented service needs.

3. Ensuring the client's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan, and requesting additional information as needed.

4. Coordinating transitions from a hospital, nursing facility, or other agency to IHSS. Assisting client with transitions from IHSS to alternate services if appropriate.

5. Collaborating with the client or their Authorized Representative and the IHSS Agency in the event of any change in condition. The Case Manager shall request an updated Physician Attestation of Consumer Capacity form. The Case Manager may revise the Care Plan as appropriate given the client's condition and functioning.

6. Completing a reassessment if requested by the client as described at Section 8.393.2.D., if level of care or service needs have changed.

8.552.7.F. The Case Manager shall not authorize more than one consumer-directed program on the client's PAR.

8.552.7.G. The Case Manager shall participate in training and consultative opportunities with The Department's Consumer-Directed Training & Operations contractor.

8.552.7.H. Additional requirements for Case Managers:

1. Contact the client or Authorized Representative once a month during the first three months of receiving IHSS to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.

2. Contact the client or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.

3. Contact the client or Authorized Representative when a change in Authorized Representative occurs and continue contact once a month for three months after the change takes place.

4. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the agency, and supervision provided. The Case Manager must document and keep record of the following:

a. IHSS Care Plans;

b. In-home supervision needs as recommended by the Physician;

c. Independent Living Core Services offered and provided by the IHSS Agency; and

d. Additional supports provided to the client by the IHSS Agency.

8.552.7.I. Start of Services

1. Services may begin only after the requirements defined at Sections 8.552.2, 8.552.6.E., 8.552.6.I., and 8.552.7.C. have been met.

2. Department review for cost-containment as defined at Sections 8.486.80 and 8.506.12 must be completed prior to issuance of the PAR to the IHSS Agency.

3. The Case Manager shall establish a service period and submit a PAR, providing a copy to the IHSS Agency prior to the start of services.

8.552.8 REIMBURSEMENT AND SERVICE LIMITATIONS

8.552.8.A. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and PAR must be submitted and approved by the Case Manager and received by the IHSS Agency prior to services being rendered. Services rendered in advance of approval and receipt of these documents are not reimbursable.

8.552.8.B. IHSS Personal Care services must comply with the rules for reimbursement set forth at Section 8.489.50. IHSS Homemaker services must comply with the rules for reimbursement set forth at Section 8.490.5.

8.552.8.C. Family Members are authorized to provide only Personal Care services or Health Maintenance Activities for eligible adults and Health Maintenance Activities for eligible children.

8.552.8.D. Services rendered by an Attendant who shares living space with the client or Family Members are reimbursable only when there is a determination by the Case Manager, made prior to the services being rendered, that the services meet the definition of Extraordinary Care.

8.552.8.E. Family Members shall not be reimbursed for more than forty (40) hours of Personal Care services in a seven (7) day period.

8.552.8.F. Health Maintenance Activities may include related Personal Care and/or Homemaker services if such tasks are completed in conjunction with the Health Maintenance Activity and are secondary or contiguous to the Health Maintenance Activity.

a. Secondary means in support of the main task(s). Secondary tasks must be routine and regularly performed in conjunction with a Health Maintenance Activity. There must be documented evidence that the secondary task is necessary for the health and safety of the client. Secondary tasks do not add units to the care plan.

b. Contiguous means before, during or after the main task(s). Contiguous tasks must be completed before, during, or after the Health Maintenance Activity. There must be documented evidence that the contiguous task is necessary for the health and safety of the client. Contiguous tasks do not add units to the care plan.

c. The IHSS Agency shall not submit claims for Health Maintenance Activities when only Personal Care and/or Homemaking services are completed.

8.552.8.G. Restrictions on allowable Personal Care units shall not apply to parents who provide Attendant services to their eligible adult children under In-Home Support Services as set forth at Section 8.485.204.D.

8.552.8.H. The IHSS Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved PAR. The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.

8.522.8.I. The IHSS Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.

8.552.8.J. Services by an Authorized Representative to represent the client are not reimbursable. IHSS services performed by an Authorized Representative for the client that they represent are not reimbursable.

8.552.8.K. An IHSS Agency shall not be reimbursed for more than twenty-four hours of IHSS service in one day by an Attendant for one or more clients collectively.

8.552.8.L. A client cannot receive IHSS and Consumer Directed Attendant Support Services (CDASS) at the same time.

8.552.8.M. Independent Living Core Services, attendant training, and oversight or supervision provided by the IHSS Agency's Licensed Health Care Professional are not separately reimbursable. No additional compensation is allowable for IHSS Agencies for providing these services.

8.552.8.N. Travel time shall not be reimbursed.

8.552.8.O. Companionship is not a benefit of IHSS and shall not be reimbursed.

8.552.9 DISCONTINUATION AND TERMINATION OF IN-HOME SUPPORT SERVICES

8.552.9.A. A client may elect to discontinue IHSS or use an alternate service-delivery option at any time.

8.552.9.B. A client may be discontinued from IHSS when equivalent care in the community has been secured.

8.552.9.C. The Case Manager may terminate a client's participation in IHSS for the following reasons:

1. The client or their Authorized Representative fails to comply with IHSS program requirements as defined in Section 8.552.4, or

2. A client no longer meets program criteria, or

3 The client provides false information, false records, or is convicted of fraud, or

4. The client or their Authorized Representative exhibits Inappropriate Behavior and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.

    a. The IHSS Agency and Case Manager are required to assist the client or their Authorized Representative to resolve the Inappropriate Behavior, which may

include the addition of or a change of Authorized Representative. All attempts to resolve the Inappropriate Behavior must be documented prior to notice of termination

8.552.9.D. When an IHSS Agency discontinues services, the agency shall give the client and the client's Authorized Representative written notice of at least thirty days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice shall be considered given when it is documented that the client or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the Case Management Agency.

1. Exceptions will be made to the requirement for advanced notice when the IHSS Agency has documented that there is an immediate threat to the client, IHSS Agency, or Attendants.

2. Upon IHSS Agency discretion, the agency may allow the client or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

8.552.9.E. If continued services are needed with another agency, the current IHSS Agency shall collaborate with the Case Manager and client or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the client’s safety and welfare.

8.552.9.F. In the event of discontinuation or termination from IHSS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for termination, information about the client’s rights to fair hearing, and appeal procedures. Once notice has been given, the client or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Services for Individuals with Intellectual and Developmental Disabilities Sections 8.609.5 and 8.609.7
Rule Number: MSB 21-02-05-A
Division / Contact / Phone: OCL / Cassandra Keller / 5181

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 21-02-05-A, Revision to the Medical Assistance Act Rule concerning Services for Individuals with Intellectual and Developmental Disabilities Sections 8.609.5 and 8.609.7

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   10 CCR 2505-10 Sections 8.609.5 and 8.609.

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.609.5 with the proposed text beginning at 8.609.5 through the end of 8.609.5.A.17. Replace the current text at 8.609.7 with the proposed text beginning at 8.609.7.A through the end of 8.609.7.C.11. This rule is effective May 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Services for Individuals with Intellectual and Developmental Disabilities Sections 8.609.5 and 8.609.7
Rule Number: MSB 21-02-05-A
Division / Contact / Phone: OCL / Cassandra Keller / 5181

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The Department is proposing several revisions to the Residential Habilitation Service and Supports (RHSS) and Individual Residential Services and Supports (IRSS) regulations. These proposed regulations build off stakeholder engagement and rule revisions that were completed in 2019. Since the implementation of the revised regulations, the Department has worked with the Colorado Department of Public Health and Environment (CDPHE) and the Division of Housing (DOH) on gaps in the regulations. The sister agencies have expressed concerns for the health, safety and welfare of participants receiving residential services due to a lack of oversight of the residential settings and an inability to cite organizations for improper care or oversight. The proposed changes will help to close the identified gaps in the regulations and enhance the Department's oversight of our residential settings.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021); Sections 25.5-10 C.R.S.

Initial Review **03/11/22** Final Adoption **04/08/22**
Proposed Effective Date **05/30/22** Emergency Adoption

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Services for Individuals with Intellectual and Developmental Disabilities Sections 8.609.5 and 8.609.7
Rule Number: MSB 21-02-05-A
Division / Contact / Phone: OCL / Cassandra Keller / 5181

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This proposed rule will directly affect Program Approved Service Agencies (PASA) and the direct care providers that they contract with. The Department does not anticipate increased costs from these regulations. Program participants will benefit from increased oversight and regulatory requirements proposed in the rule. The anticipated benefits include increased provider accountability and credentialing of direct care providers.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   This proposed rule will have a positive impact by enhancing the health, safety and welfare of participants receiving residential services by improving the oversight of the residential settings and thus creating the ability to cite organizations for improper care or oversight. Quantitatively, providers will be required to complete member satisfaction surveys more frequently, ensuring members are receiving services in the manner they prefer.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or to any other agency as a product of the implementation and enforcement of these proposed rules.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   There are no costs to the Department as a product of the proposed rules. The proposed changes will help to close the identified gaps in the regulations and enhance the Department's oversight of our residential settings and thus improve member health and safety in their residential setting.

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5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The Department held five stakeholder meetings to collaborate on the changes to the regulations and present subsequent drafts to the group. It was determined that the proposed rules were the least intrusive while still achieving improved oversight of these residential settings.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department held five stakeholder meetings to collaborate on the changes to the regulations and present subsequent drafts to the group. The proposed regulations are the best method for creating standards for services and oversight, as well as providing the Department of Public Health and Environment a regulatory framework with which they can ensure compliance.

8.609 PROGRAM SERVICES AND SUPPORTS

8.609.5 RESIDENTIAL HABILITATION SERVICES AND SUPPORTS DESCRIPTION AND GENERAL PROVISIONS

Residential Habilitation Services and Supports provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training (i.e., instruction, skill acquisition) and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services and supports are designed to meet the unique needs of each person determined by the assessed needs, personal goals, and other input provided by the Interdisciplinary Team, defined at ~~10 CCR 2505-10,~~ Section 8.519.1, and to provide access to and participation in typical activities and functions of community life.

A. Program Approved Service Agency Policies, Procedures and Service Provisions

1. Each Program Approved Service Agency (PASA) providing residential services must establish and implement written policies and procedures concerning the use, ~~and~~ handling and timely disbursement of personal needs funds and include a record of personal possessions, including clothing, of the participant.

2. PASA~~'~~s must conduct an evaluation of consumer satisfaction with services and supports no less than every ~~three~~ two years. The PASA must review and analyze this data and address any complaints or problematic practices requiring corrective action. PASAs must make the results of the survey available to interested stakeholders upon request. ~~PASA~~

3. The PASA must maintain a record for each participant which includes the information required by these rules and as prescribed by the Department.

4. Participants receiving Residential Habilitation Services and Supports must have 24-hour supervision. Supervision may be on-site (direct service provider or caregiver is present) or accessible (direct service provider or caregiver is not on site but available to respond when needed). Staffing arrangements must be adequate to meet the health, safety and welfare of participants and the needs of the individual as determined by the Service Plan. The PASA is responsible for verifying that any direct care provider they employ or contract with has the capacity to serve the individuals in their care, as outlined in the Support Plan.

5. Physical facilities utilized as residential settings must meet all applicable fire, building, licensing and health regulations.

6. Services and supports must be provided pursuant to the person's Service Plan, in accordance with Department guidelines and service descriptions, and the HCBS Settings Final Rule at 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified in relevant part at 42 C.F.R. § 441.301).

7. The PASA is responsible for providing services, supplies and equipment as prescribed by the Department.

8. Caregivers, providers and other support personnel must have ready access to records and all necessary, detailed protocols about the participant required to carry out their responsibilities.

9. PASA~~'~~s must comply with the Colorado Adult Protection Services (CAPS) requirements, outlined in §26-3.1-111, C.R.S. and 12 CCR 2518-1, Volume 30.960. The PASA must maintain accurate records and make records available to the Department upon request.

   a. Direct service provider means any person providing direct services and supports, including case management services, protective services, physical care, mental health services, or any other service necessary for the at-risk adult's health, safety, or welfare, pursuant to C.R.S. 26-3.1-101 (3.5). Direct service provider includes PASA applicants and owners, as they are ultimately responsible for the members they serve.

   b. ~~-~~During the enrollment process the PASA may be granted provisional approval to render Medicaid services. Final PASA approval is contingent on submission of documentation of a completed CAPS check on the PASA applicant and owner within 90 days from the receipt of the provisional approval.

      i. Failure to submit the required documentation within 90 days of the provisional approval period may result in rescindment of the provisional approval.

      ii. For the purposes of C.R.S. 26-3.1-111 (6)(a)(III), the Department of Health Care Policy and Financing is the oversight agency for PASAs and must be informed of CAPS check results for employers who run them on themselves.

   c. Direct Service and backup providers with any of the following are prohibited from providing IRSS to any participant ~~Direct service and backup providers will be prohibited from providing IRSS to any participant with any of the following substantiated allegations~~:

      i. A substantiated allegation of abuse, neglect, exploitation, or harmful act, as defined in Section 26-3.1-101, C.R.S., within the last 10 years, by APS at a severity level of "Moderate" or "Severe" as defined in 12 CCR 2518-1 Section 30.100;

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

      iii. A criminal conviction of abuse, neglect, or exploitation against an at-risk adult with IDD as defined in Section 18-6.5-102, C.R.S.

      iv. Only substantiated allegations that have exhausted the appeal period and come to a final disposition, as defined as 12 CCR 2518-1 Section 30.920, shall be included in the above exclusions list.

10. Incident Reporting

   a. The PASA must comply with all incident reporting requirements, as outlined in ~~10 CCR 2505-10,~~ Section 8.608.6.

b. The PASA must notify guardians and/or representatives of Incident Reports (IR).

c. The PASA must have policies and procedures in place for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any participant, pursuant to ~~10 CCR 2505-10,~~ Section 8.608.8.

d. The PASA must notify the waiver participant and guardians and/or participants' representatives of investigations, including summary information pertaining to the outcome of the investigation, victim supports accessed, and recommendations to prevent recurrence.

11. The PASA is responsible for the monitoring of conditions at the property and must provide oversight and guidance to safeguard the health, safety, and welfare of the participant.

12. The PASA must provide for and document the regular on-site monitoring of Residential Habilitation Services and Supports. PASA's must conduct an on-site visit of each Individual Residential Support Services (IRSS) or Group Residential Support Services (GRSS) setting before a participant moves in, and at a minimum once every quarter, with at least one visit annually that is unscheduled. On-site monitoring of IRSS and GRSS settings must include, but not be limited to:

    a. Inspection of all smoke alarms and carbon monoxide detectors;

    b. Ensuring all exits are free from blockages to egress;

    c. Review of each participant's emergency and disaster assessment; and

    d. Medication administration records and physician orders.

~~13. The PASA must have a protocol in place for the emergency placement of the participant if a home is deemed not safe by the Division of Housing (DOH).~~

~~14. The PASA must have a written contract with each direct service provider providing IRSS under the PASA's authority, such as a Host Home provider or family caregivers not directly employed by the PASA.~~

~~a. A current list of the above-mentioned contracted IRSS providers and their accompanying contracts must be on file with the program approved service agency and a copy must be provided to the Department or its agent upon request.~~

~~b. Each contract must be in writing and contain the following information:~~

~~i. Name of contracted IRSS provider;~~

~~ii. Responsibilities of each party to the contract, including, but not limited to, responsibility for the safety and accessibility of the physical environment of the home;~~

~~iii. process for correcting non-compliance;~~

~~iv. process for termination of the contract;~~

~~v. process for modification or revision of the contract;~~

vi. process for relocation of the participant if they are in immediate jeopardy;

vii. process for coordinating the care of the participant;

vii. Payment rate and method; and

viii. Beginning and ending dates.

c. If a contract is terminated with a contracted IRSS provider due to health, safety or welfare concerns, the PASA must report to the following parties:

i. Within 430 days to the Department or its agent regarding the cited reason for termination of a contracted IRSS provider.

ii. Within 410 days to the guardian or authorized representative and case manager of the participant from the terminated contracted IRSS provider.

15. The PASA must require each contracted direct service provider providing IRSS to document each approved caregiver(s) and report to the agency the names of all persons that reside in the home.No backup provider may be hired without PASA approval. The agency must ensure criminal background checks are completed for any non-participant over the age of 18 who lives in the home.

i. mistreatment, abuse, neglect, or exploitationIRSS.

16. The Host Home must be the primary residence of the Host Home provider. A Host Home provider is not permitted to to any not living in their Host Home.

17. Each PASA must provide quarterly housing and participant updates to the Department or its agent through a specified data collection platform. Failure to provide these quarterly updates result in payment suspension.

B. Rights of Participants

1. A participant must be presumed able to manage his/her own funds and possessions unless otherwise documented in the Service Plan.

2. Participants must have a key or key code to their home, a bedroom door with a lock, lockable bathroom doors, access to all common areas of the home, and a residential agreement that provides protections for evictions.

3. A participant, guardians, authorized representatives, as appropriate, and the case manager shall be notified at least fifteen (15) days prior to proposed changes in residential placements.

a. If an immediate move is required for the protection of the person, notification must occur as soon as possible before the move or no later than three days after the move.

b. A participant, guardians, and authorized representatives, as appropriate, must be involved in planning subsequent placements and any member of the Interdisciplinary Team may request a meeting to discuss the change in placement.

c. When a participant moves settings or PASA, all residential PASA's involved must be present for the move whenever possible, and will ensure all possessions, medications, money and pertinent records are transferred to the participant within 24 hours.

d. If the participant, guardians, or authorized representative, as appropriate, wants to contest the move they should follow the grievance procedure of the agency.

e. If there is a concern regarding the health, safety, or welfare of the person being jeopardized as a result of the move, any interested party may request an emergency order from the Department pursuant to Section 8.605.4.

4. Participants have a right to annual notification of PASA appeal/grievance policies and procedures.

8.609.7 INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) SPECIFICATIONS

A. Individual Residential Services and Supports (IRSS) use a variety of living arrangements to meet the unique needs for support, guidance and habilitation of each participant.

1. IRSS settings include, but are not limited to:

a. a home owned, ~~or~~ leased or controlled by the Program Approved Service Agency (PASA);

~~a Host Home, or~~

b. a home of a family member;

c. their own home; or ~~.~~

d. a Host Home.

i. The Host Home is the primary residence of the provider, which means that the Host Home provider occupies the residence seventy-five (75) percent of the time. The Host Home provider may not contract to provide services to more than three (3) individuals, inside or outside of the Host Home, at any given time.

~~A~~B. Program Approved Service Agency Policies, Procedures and Service Provisions

1. The ~~Program Approved Service Agency (~~PASA~~)~~ has the responsibility for the living environment, regardless of the setting type.

2. IRSS may be provided to no more than three participants in a single setting. For each participant in a setting, the PASA must ensure the following criteria are met and documented~~:~~:

a. The participants involved elect to live in the setting;

b. Each participant must have their own bedroom, unless they elect to share a bedroom with a roommate of their choice, which must be documented in the Service Plan;

c. Back-up providers are identified, available and agreed upon by the participant and PASA. When a back-up provider is not available, the PASA assumes responsibility for identifying a provider;

d. The PASA and case management agency of each participant in the setting must be involved in the coordination of placement of each participant;

e. Participants are afforded regular opportunities for community inclusion of their choice;

f. Participants are afforded individual choice, including preference to live near family;

g. Distance from other homes (e.g., apartments, houses) of participants is examined so that persons with developmental disabilities are not grouped in a conspicuous manner;

h. For the placement of an individual into a three-person setting, the following factors must be examined to determine reasonableness of the placement:

i. Level of care and needs of each participant in the home;

ii. Availability to support and provide supervision to participants;

iii. Compliance with HCBS Settings Final Rule at 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified in relevant part at 42 C.F.R. § 441.301); and

iv. Each participant's ability to evacuate.

i. When three participants reside in a single setting, the PASA must conduct monthly monitoring of the setting.

3. Participants must live safely in environments common to other citizens with reasonable and appropriate supports provided to protect their health and safety while simultaneously promoting community inclusion. Providers and caregivers must have the appropriate knowledge, skills, and training to meet the individual needs of the participant before providing care and services. The PASA must have policies and procedures in place outlining the required trainings for providers and caregivers. The policy and procedure shall include, but not be limited to, the following:

a. Training specific to the participants' needs shall be completed by all providers and caregivers. Such training shall include, at a minimum, medical protocols and activities of daily living needs.

b. Providers and caregivers shall receive training in resident rights, abuse and neglect prevention, and reporting abuse, neglect, mistreatment and exploitation.

4. Upon enrollment in services, the PASA must assess each participant's ability to care for their safety needs and take appropriate action in case of an emergency. The assessment must be kept up to date and, at a minimum, address the following emergencies and disasters:

a. Fire;

b. Severe weather and other natural disasters;

c. Serious accidents and illness;

d. Assaults; and,

e. Intruders.

5. There must be a written plan for each person addressing how the emergencies specified above will be handled. The plans must be based on an assessment, maintained current and shall, at minimum, address:

   a. Specific responsibilities/actions to be taken by the participant, approved caregivers or other providers of supports and services in case of an emergency;

   b. How the participant will evacuate in case of fire by specifying, at minimum, two exit routes from floors used for sleeping and the level of assistance needed; and

   c. Telephone access (by the participant or with assistance) to the nearest poison control center, police, fire and medical services.

6. Safety plans and evacuation procedures must be reviewed and practiced at sufficient frequency and varying times of the day, but no less than once a quarter, to ensure all persons with responsibilities for carrying out the plan are knowledgeable about the plan and capable of performing it. All safety plans must be on site at the home and be reviewed by the PASA agency during each on-site monitoring visit.

7. The PASA must provide sufficient oversight and guidance and have established procedures to ensure that the health and medical needs of the participant are addressed. This includes:

   a. Each participant must have a primary physician;

   b. Each participant must receive a medical evaluation at least annually unless a greater or lesser frequency is specified by his/her primary physician. If the physician specifies an annual evaluation is not needed, a medical evaluation must be conducted no less frequently than every two years;

   c. Each participant must be encouraged and assisted in getting a dental evaluation annually;

   d. Other medical and dental assessments and services must be completed as the need for these is identified by the physician, dentist, other medical support personnel or the Interdisciplinary Team; and

   e. Records must contain documentation of:

      i. medical services provided;

      ii. results of medical evaluations/ assessments and of follow-up services required, if any;

      iii. acute illness and chronic medical problems; and,

iv. weight taken annually or more frequently, as needed.

8. The PASA must have a written contract with each direct service provider that is not directly employed by the PASA and is providing IRSS under the PASA's authority, regardless of the setting type. This includes but is not limited to Host Home providers and family caregivers not directly employed by the PASA.

a. A current list of the above-mentioned contracted IRSS providers and their accompanying contracts must be on file with the program approved service agency and a copy must be provided to the Department or its agent upon request.

b. Each contract must be in writing and contain the following information:

i. Name of contracted IRSS provider;

ii. Responsibilities of each party to the contract, including, but not limited to, responsibility for the safety and accessibility of the physical environment of the home;

iii. An agreement outlining the living arrangements, monitoring of the Host Home, Host Home provider's duties, and any limitations on the Host Home providers duties;

iv. Expectations that participants be provided opportunities for informed choice over a variety of daily choices similar to those exercised by non-participants;

v. Process for correcting non-compliance;

vi. Process for termination of the contract;

vii. Process for modification or revision of the contract;

viii. Process for relocation of the participant if they are in immediate jeopardy of actual or potential for serious injury or harm;

ix. Process for coordinating the care of the participant;

x. Payment rate and method; ~~and~~

xi. Beginning and ending dates; and

xii. A clause that states the contracted IRSS provider shall not sub-contract with any entity to perform in whole the work or services required under the IRSS benefit.

c. PASAs who utilizes the services of subcontractors are responsible for the following, which includes but i~~s~~t not limited to:

i. Vetting, training, monitoring, and taking corrective action with employees and subcontractors.

ii. Nothing in these regulations shall create any contractual relationship between any subcontractor of the PASA and the Department.

d. If a contract is terminated with a contracted IRSS provider due to health, safety or welfare concerns, the PASA must report to the following parties:

i. Within 4 days to the Department or its agent regarding the cited reason for termination of a contracted IRSS provider.

ii. Within 4 days to the guardian or authorized representative and case manager of the participant from the terminated contracted IRSS provider.

9. The PASA must require each contracted direct service provider providing IRSS to document each approved caregiver(s) and report to the agency the names of all persons that reside in the home. Participants and/or guardians have a right to request and receive from the rendering PASA a list of all direct service and backup providers that are approved to provide them services. No backup provider may be hired without PASA approval. The agency must ensure criminal background checks are completed for any non-participant over the age of 18 who lives in the home.

10. The IRSS direct service provider is prohibited from conduct that would pose a risk to the health, safety and welfare of the member including the members mental health.

11. Each PASA must provide quarterly housing and participant updates to the Department or its agent through a specified data collection platform. Failure to provide these quarterly updates may result in payment suspension.

12. The PASA must ensure nutritionally balanced meals are available to participants. Based on an assessment of the person's capabilities, preferences and nutritional needs, the PASA may provide guidance and support to monitor nutritional adequacy.

a. Therapeutic diets must be prescribed by a licensed physician or dietician.

b. Participants must have access to food at all times, choose when and what to eat, the opportunity to provide input into menu planning, comfortable seating for meals where they can choose their own seat, and shall have access to food preparation areas as documented in the Service Plan.

~~B~~C. Living Environment

1. Homes of participants must, at minimum, meet standards set forth in the Colorado Division of Housing (DOH) IRSS Inspection Protocol. The following setting types must pass the DOH IRSS Inspection Protocol every two years:

a. All Host Homes; and

b. All IRSS settings that are owned or leased by a PASA.

Settings must request an inspection prior to placement of a participant and must pass an inspection within 90 days of becoming an approved setting and providing services. Existing settings have until January 1, 2022 to pass an inspection.

2. The PASA must have a protocol in place for the emergency placement of the participant if a home is deemed not safe by the Division of Housing (DOH).

3. The home (exterior and interior) and grounds must:

a. Be maintained in good repair;

b. Protect the health, comfort and safety of the participant; and

c. Be free of offensive odors, accumulation of dirt, rubbish and dust.

43. There must be two means of exit from floors with rooms used for sleeping. Exits must remain clear and unobstructed.

54. The PASA must ensure entry to the home and an emergency exit is accessible to participants, including participants utilizing a wheelchair or other mobility device.

65. The PASA must ensure that participants who utilize a wheelchair or other mobility device have access to all common areas of the home

76. Bedrooms must meet minimum space requirements (single 80 square feet, double 120 square feet). (Not applicable for studio apartments.)

87. Adequate and comfortable furnishings and supplies must be provided and maintained in good condition.

98. Participants have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment.

109. A fire extinguisher must be available in each home. Presence of an operational fire extinguisher shall be confirmed by the PASA during each on-site monitoring visit.

a. PASA's must follow manufacturer specifications and expiration dates for all fire extinguishers.

110. Smoke alarms and carbon monoxide detectors must be installed in the proper locations in each home to meet Housing and Urban Development (HUD) requirements and/or local ordinances. Smoke and carbon monoxide detectors shall be tested during each on-site monitoring visit by the PASA.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Abortion Services, Section 8.770
Rule Number: MSB 22-02-27-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-02-27-A, Revision to the Medical Assistance Rule concerning Abortion Services, Section 8.770

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.770, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.770.4 with the proposed text beginning at 8.770.4.B through the end of 8.770.4.E. This rule is effective May 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Abortion Services, Section 8.770
Rule Number: MSB 22-02-27-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule aligns Department rule with current policy and the requirements of Senate Bill 21-142, enacted at Colorado Revised Statute, Section 25.5-4-415, which authorized providers licensed by the state and acting within their scope of practice and federal regulations to perform abortions reimbursed by Medicaid, and removed the requirement that abortions reimbursed by Medicaid be performed in a licensed health care facility.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   C.R.S. § 25.5-4-415 (2021)

Initial Review — Final Adoption **04/08/22**
Proposed Effective Date **05/30/22** — Emergency Adoption

DOCUMENT #05

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members receiving an abortion are affected by the proposed rule and non-physician providers, licensed by the state and acting within their scope of practice and federal regulations, performing Medicaid-reimbursed abortions are affected by the proposed rule.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Members are not restricted to receiving abortions at licensed health care facilities and non-physician providers, licensed by the state and acting within their scope of practice and federal regulations, are reimbursed by Medicaid for performing abortions.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The fiscal note for Senate Bill 21-142 assumed some abortions may be performed at different facilities and by providers other than physicians, but that the amount of abortions performed will be unchanged. As such, no increase in medical services expenditures was anticipated.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   There are no probable costs for the proposed rule. The benefit of the proposed rule is aligning Department rule with current policy and state statute. The cost of inaction is misalignment between Department rule, current policy, and state statute. There are no benefits to inaction.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no less costly methods or less intrusive methods for aligning Department rule with current policy and state statute.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for aligning Department rule with current policy and state statute.

8.770 ABORTION SERVICES

8.770.1. Definitions

Life-Endangering Circumstance means:

1. The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term; or

2. The presence of a psychiatric condition, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such cases, unless the pregnant woman has been receiving prolonged psychiatric care, the attending physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition.

8.770.2. Client Eligibility

8.770.2.A. All Colorado Medicaid-enrolled clients are eligible.

8.770.3. Provider Eligibility

8.770.3.A. All Colorado Medicaid enrolled providers in compliance with CRS § 25.5-3-106 are eligible to perform abortion services.

8.770.4. Covered Services

8.770.4.A. Abortion services are only covered when the life of the mother would be endangered if the fetus were carried to term; or when the pregnancy is the result of an act of rape or incest.

8.770.4.B. In cases of a life-endangering circumstance, the physician must make every reasonable effort to preserve the lives of the pregnant woman and the ~~unborn child~~fetus.

8.770.4.C. A provider who is licensed ~~physician~~ by the state and acting within the scope of the provider's license and in accordance with applicable federal regulations shall perform the procedure ~~in a licensed health care facility. When the pregnancy substantially threatens the life of the client, and the transfer to a licensed health care facility would, in the medical judgment of the attending physician, further threaten the life of the client, the abortion may be provided outside of a licensed health care facility~~.

8.770.4.D. Any claim for payment must be accompanied by a case summary that includes the following information:

1. Name, address, and age of the pregnant woman;

2. Gestational age of the ~~unborn child~~fetus;

3. Description of the medical condition which necessitated the abortion;

4. Services performed;

5. Facility in which the abortion was performed; and

6. Date of service.

8.770.4.E. A claim for payment for an abortion that is the result of life-endangering circumstances must also be accompanied by a Department-approved certification statement confirming the life-endangering circumstance of the abortion and at least one of the following forms with additional supporting documentation that confirms the life-endangering circumstances:

1. Hospital admission summary

2. The findings and reports from consultants that provide opinions regarding the health of the client

3. Laboratory results and findings

4. Office visit notes

5. Hospital progress notes

8.770.4.F. A claim for payment for an abortion that is the result of rape or incest must be accompanied by a Department-approved certification statement confirming the circumstances of the abortion.

8.770.4.G. An evaluation by a licensed physician specializing in psychiatry must accompany the claim for reimbursement for the abortion if a psychiatric condition represents a serious and substantial threat to the pregnant woman's life if the pregnancy continues to term.

8.770.5. Prior Authorization Requirements (PAR)

8.770.5.A. Prior authorization is not required for this service.