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Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule concerning Life Skills Training, Home Delivered Meals, Peer Mentorship, & Transition Setup Services
Rule Number: MSB 22-07-19-A
Division / Contact: OCL / Sarah Hoerle

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 22-07-19-A Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule concerning Life Skills Training, Home Delivered Meals, Peer Mentorship, & Transition Setup Services, Section 8.553

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) 8.553, 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 No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). YesYes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.553 with the proposed text beginning at 8.553 through the end of 8.553.7. This rule is effective April 14, 2023.

*to be completed by MSB Board Coordinator

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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).

   Section 8.553 governs Home Delivered Meals for individuals receiving HCBS benefits under the Developmental Disabilities (DD), Supported Living Services (SLS), Elderly, Blind, and Disabled (EBD), Community Mental Health Supports (CMHS), Complementary and Integrative Health (CIH) and Brain Injury (BI) waivers. Currently, a hospital stay does not independently justify the provision of Home Delivered Meals post-discharge, even if the member's performance in activities of daily living is more limited than baseline. As described below, this places members at increased risk of malnutrition and rehospitalization.

   To reduce these risks, and improve members' nutrition, health, and outcomes after hospitalization, the Department received a waiver amendment from the Center for Medicare and Medicaid Services (CMS) to provide Home Delivered Meals to eligible waiver members who have been discharged from the hospital.

   The Department is revising this section of the rule to implement this waiver amendment. These changes include eligibility criteria and utilization parameters for the new benefit.

   Additional changes in this section of the rule include updating references of the Spinal Cord Injury (SCI) waiver to the Complementary and Integrative Health (CIH) waiver, clarifying eligibility criteria for the transition services benefits, and updating provider requirements for Peer Mentorship.

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:

Initial Review **01/13/23** Final Adoption **02/10/23**
Proposed Effective Date **03/30/23** Emergency Adoption

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303 C.R.S. (2022); Sections 25.5-6-1501 C.R.S. (2022); 25.5-6-404 C.R.S. (2022); 25.5-6-704 C.R.S. (2022); 25.5-6-606 C.R.S. (2022).

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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.

   Individuals who will be affected by this rule are members receiving services under the Developmental Disabilities (DD), Supported Living Services (SLS) Elderly Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Complementary and Integrative Health (CIH), and Brain Injury (BI) waivers who have been discharged from the hospital after having been admitted for at least 24 hours. Members and providers will benefit from this rule change, but they will not bear any cost from this rule change. The Department will bear the cost of this rule change.

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

   Qualitatively, the expanded Home Delivered Meals Benefit is expected to ensure proper nutrition to HCBS waiver members post-hospital discharge and will promote faster healing, lessen caregiver stress, and reduce the risk of health deterioration. A study published by the National Institutes of Health evaluated the impacts of a nutrition-focused quality improvement program for malnourished patients that have been hospitalized and found that nutritional interventions diminished the negative effects of malnutrition and improved patient health outcomes. The nutritional support also reduced the per-patient health care costs from patients by avoiding 30-day readmissions and reducing the length of hospital stay. Suela Sulo, Josh Feldstein, Jamie Partridge, Bjoern Schwander, Krishnan Sriram, & Wm. Thomas Summerfelt, *Budget Impact of a Comprehensive Nutrition-Focused Quality Improvement Program for Malnourished Hospitalized Patients*, Vol. 10, 5 Am. Health Drug Benefits, 262-270, (July 2017).

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.

   Per the Budget Request approved through R-09 of the Long Bill for SFY 2022-23, it is estimated that the total cost to the Department of the Home Delivered Meals benefit

expansion will be $459,269 with an estimated savings in reduced hospital admissions of $718,868 in FY 22-23. This is a total net savings of $259,599. In FY 23-24, there is an estimated cost of $917,129 for the expanded HDM benefit. There is an estimated savings from reduced hospital admissions of $1,451,399 with a cost savings of $534,270.

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

   Estimated savings from the policy are in the form of a reduction in hospital readmissions within 30 days of discharge. The 2018 study, "From Hospital to Home: Why Nutrition Counts," showed that post-discharge nutrition-focused transition programs reduced hospital readmissions by 29 percent. Wendy Everett, Christina Badaracco, & Sharon McCauley *From Hospital to Home: Why Nutrition Counts*, Health Affairs, 10.1377 https://www.healthaffairs.org/do/10.1377/forefront.20200117.329745/full/, (Accessed December 29, 2022). The Department assumes 29% of readmitted hospitals stays within 30 days of discharge will be avoided with this service expansion in the first year of implementation. The Department increased this reduction assumption to 41% by FY 2023-24, which is the average of a 29% decline and a 52% decline in hospital readmission cited in two studies. *See* Everett, *supra*; Kurt Hager, Frederick P. Cudhea, John B. Wong, et al., *Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US*, Association of National Expansion of Insurance. JAMA Netw Open. 2022;5(10):e2236898. doi:10.1001/jamanetworkopen.2022.36898 (Accessed December 29, 2022).

   Additionally, the implementation of a medically tailored meals benefit could potentially be associated with as many as 1.6 million averted hospitalizations with a net cost savings of $13.6 billion annually. Hager, *supra*. Further, a 2017 study found that a transition program focused on continuing the nutrition care plan for malnourished patients post-discharge led to a 29 percent decline in all-cause 30-day readmissions, a 26 percent reduction in hospital length-of-stay, and $3,800 in savings per patient. Sulo*, supra* at Tables 1 & 2.

   If this request is not approved, HCBS waiver members who are at a high-risk for malnutrition will continue to be at risk for hospital readmissions post-discharge, which is a far more expensive care setting compared to services offered through the HCBS waivers.

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 available. Revising these regulations to implement this budgetarily appropriated change to include the new requirements is required for implementation.

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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.

   No other alternative methods were considered. In order to implement this change in alignment with the waiver amendment, a rulemaking is needed.

8.553 LIFE SKILLS TRAINING, HOME DELIVERED MEALS, PEER MENTORSHIP, ~~&~~ TRANSITION SETUP SERVICES, & HOME DELIVERED MEALS POST-HOSPITAL DISCHARGE

8.553.1 GENERAL DEFINITIONS

A. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a service plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic reassessment of such individual's needs.

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

C. Community risk level means the potential for a ~~client~~ member living in a community-based arrangement to require emergency services, to be admitted to a hospital or nursing facility, evicted from their home or involved with law enforcement due to identified risk factors.

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

E. Discharge means a release from the hospital following a minimum ~~of~~ 24-hour stay following admission.

~~E.~~F. Home and Community Based Services (HCBS) Waivers means services and supports provided through a waiver authorized in Section 1915(c) of the Social Security Act, 42 U.S.C. Section 1396n(c) and provided in community settings to a ~~client~~ member who requires an institutional level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

~~F.~~G. Home Delivered Meals means nutritional counseling, planning, preparation, and delivery of meals to ~~clients~~ members who have dietary restrictions or specific nutritional needs, are unable to prepare their own meals, and have limited or no outside assistance.

~~G.~~H. Institutional Setting means an institution or institution-like setting, including a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Regional Center or Home and Community Based setting that is operated by the state.

~~H~~I. Life Skills Training (LST) means individualized training designed and directed with the ~~client~~ member to develop and maintain his/her ability to independently sustain himself/herself physically, emotionally, socially and economically in the community. LST may be provided in the ~~client's~~ member's residence, in the community, or in a group living situation.

~~I.~~J. Life Skills Training program service plan is a plan that describes the type of services that will be provided as part of the LST, and the scope, frequency, and duration of services necessary to meet the client's needs, enabling the ~~client~~ member to independently sustain himself/herself physically, emotionally, socially, and economically in the community. This plan must be developed with input from the ~~client~~ member and the provider.

K. Member has the same meaning and use as the terms "Member" and/or "Client" in used Section 8.500.1, 8.500.90, .

~~J.~~L. ~~K.~~ Nutritional Meal Plan is a plan consisting of the complete nutritional regimen that the Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) recommends to the ~~individual~~ member for overall health and ~~wellness, and~~wellness and shall include additional recommendations outside of the Medicaid-authorized meals for additional nutritional support and education.

~~K.~~LM. Peer Mentorship means support provided by peers to promote self-advocacy and encourage community living among ~~clients~~ members by instructing and advising on issues and topics related to community living, describing real-world experiences as examples, and modeling successful community living and problem-solving.

~~L.~~MN. Service Plan means the written document that identifies approved services, including Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a ~~client~~ member to remain safely in the community and developed in accordance with the Department rules.

~~M.~~NO. Transition Setup Authorization Request Form is a document used to request authorization for delivery of items and/or services required for the transition set up to occur. This document must be submitted to and approved by the Case Management Agency in order for the provider to receive payment.

~~N.~~OP. Transition Setup means coordination and coverage of one-time, non-recurring expenses necessary for a ~~client~~~~member~~member to establish a basic household upon transitioning from a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to a community living arrangement that is not operated by the state.

8.553.2 SERVICE ACCESS AND AUTHORIZATION

A. To establish eligibility for Life Skills Training, Home Delivered Meals, or Peer Mentorship, the ~~client~~ member must satisfy two sets of criteria: general criteria for accessing any of the three services, and criteria unique to each particular service. The ~~client's~~ member's Case Manager must not authorize Life Skills Training, Home Delivered Meals, or Peer Mentorship to continue for more than 365 days. The Department, in its sole discretion, may grant an exception based on extraordinary circumstances:

1. To be eligible for Life Skills Training, Home Delivered Meals, or Peer Mentorship, the ~~client~~ member must satisfy the following general criteria:

   a. The ~~client~~member~~client~~~~member~~ is transitioning from an institutional setting to a home and community-based setting, or is experiencing a change in life circumstance that affects a ~~client~~member's stability and endangers their ability to remain in the community~~or from any change in life circumstance~~,

   b. The ~~client~~ ,member demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and

   c. The ~~client~~member demonstrates that they need the service to establish community supports or resources where they may not otherwise exist.

2. To be eligible for Life Skills Training (LST), Home Delivered Meals, and Peer Mentorship, the ~~client~~member must participate in an assessment and satisfy the criteria unique to each particular service the ~~client~~member wishes to access.

   a. To obtain approval for LST the ~~client~~member must be enrolled in the HCBS-CMHS Waiver under Section 8.509, the HCBS-EBD Waiver under Section 8.485, the HCBS-CIH Waiver under Section 8.517, or the HCBS-SLS Waiver under

Section 8.500.9. The member must also demonstrate the following needs, which must be documented in the ~~client~~member's Service Plan:

i. The ~~client~~member demonstrates a need for training designed and directed with the ~~client~~member~~member~~ to develop and maintain his/her ability to sustain himself/herself physically, emotionally, socially and economically in the community;

ii. The ~~client~~member identifies skills for which training is needed and demonstrates that without the skills, the ~~client~~member risks his/her health, safety, or ability to live in the community;

iii. The ~~client~~member demonstrates that without training he/she could not develop the skills needed; and

iv. The ~~client~~member demonstrates that with training he/she has ability to acquire these skills or services necessary within 365 days.

~~v. Life Skills Training is available in the HCBS-CMHS Waiver under Section 8.509, the HCBS-EBD Waiver under Section 8.485; the HCBS-SCI CIH Waiver under Section 8.517; and the HCBS-SLS Waiver under Section 8.500.9~~.

b. To obtain approval for Home Delivered Meals, the ~~client~~member must be enrolled in the HCBS-BI Waiver under Section 8.515, the HCBS-CMHS Waiver under Section 8.509; the HCBS-DD Waiver under Section 8.500, the HCBS-EBD Waiver under Section 8.485, the HCBS-CIH Waiver under Section 8.517, or the HCBS-SLS Waiver under Section 8.500.9. The member must also demonstrate a need for the service, as follows:

i. The ~~client~~member demonstrates a need for nutritional counseling, meal planning, and preparation;

ii. The ~~client~~member shows documented dietary restrictions or specific nutritional needs;

iii. The ~~client~~member lacks or has limited access to outside assistance, services, or resources through which he/she can access meals with the type of nutrition vital to meeting his/her dietary restrictions or special nutritional needs;

iv. The ~~client~~member is unable to prepare meals with the type of nutrition vital to meeting his/her dietary restrictions or special nutritional needs;

v. The ~~client~~member's inability to access and prepare nutritious meals demonstrates a need-related risk to health, safety, or institutionalization; and

vi. The assessed need is documented in the ~~client~~member's Service Plan as part of their acquisition process of gradually becoming capable of preparing their own meals or establishing the resources to obtain their needed meals.

~~vii. Home Delivered Meals is available in the HCBS-BI Waiver under Section 8.515; the HCBS-CMHS Waiver under Section 8.509; the HCBS-DD~~

~~Waiver under Section 8.500; the HCBS-EBD Waiver under Section 8.485; the HCBS-SCI CIH Waiver under Section 8.517; and the HCBS-SLS Waiver under Section 8.500.9.~~

c. To obtain approval for Peer Mentorship, a ~~client~~member must be enrolled in the HCBS-BI Waiver under Section 8.515; the HCBS-CMHS Waiver under Section 8.509; the HCBS-EBD Waiver under Section 8.485; the HCBS-CIH Waiver under Section 8.517; the HCBS-DD Waiver under Section 8.500; or the HCBS-SLS Waiver under Section 8.500.9. The member must also demonstrate:

i. A need for soft skills, insight, or guidance from a peer;

ii. That without this service he/she may experience a health, safety, or institutional risk; and

iii. There are no other services or resources available to meet the need.

~~iv. Peer Mentorship is available in the HCBS-BI Waiver under Section 8.515; the HCBS-CMHS Waiver under Section 8.509; the HCBS-EBD Waiver under Section 8.485; the HCBS-SCI CIH Waiver under Section 8.517; the HCBS-DD Waiver under Section 8.500; and the HCBS-SLS Waiver under Section 8.500.9.~~

8.553.3 LIFE SKILLS TRAINING (LST)

A. INCLUSIONS

1. Life Skills Training includes assessment, training, maintenance, supervision, assistance, or continued supports of the following skills:

a. Problem-solving;

b. Identifying and accessing mental and behavioral health services;

c. Self-care and activities of daily living;

d. Medication reminders and supervision, not including medication administration;

e. Household management;

f. Time management;

g. Safety awareness;

h. Task completion;

i. Communication skill building;

j. Interpersonal skill development;

k. Socialization, including, but not limited to; acquiring and developing skills that promote healthy relationships; assistance with understanding social norms and values; and support with acclimating to the community;

l. Recreation, including leisure and community engagement;

m. Assistance with understanding and following plans for occupational or sensory skill development;

n. Accessing resources and benefit coordination, including activities related to coordination of community transportation, community meetings, community resources, housing resources, Medicaid services, and other available public and private resources;

o. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting;

p. Acquiring and utilizing assistive technology when appropriate and not duplicative of training covered under other services.

All Life Skills Training shall be documented in the Life Skills Training (LST) program service plans. Reimbursement is limited to services described in the Life Skills Training (LST) program service plans.

B. LIMITATIONS AND EXCLUSIONS

1. ~~Client~~Members may utilize LST up to 24 units (six hours) per day, for no more than 160 units (40 hours) per week, for up to 365 days following the first day the service is provided.

2. LST is not to be delivered simultaneously during the direct provision of Adult Day Health, Adult Day Services, Group Behavioral Counseling, Consumer Directed Attendant Support Services (CDASS), Health Maintenance Activities, Homemaker, In Home Support Services (IHSS), Mentorship, Peer Mentorship, Personal Care, Prevocational Services, Respite, Specialized Habilitation, Supported Community Connections, or Supported Employment.

   a. LST may be provided with Non-Medical Transportation (NMT) if the transportation of the ~~client~~member is part of the LST as indicated in the LST program service plan; if not part of the training, the provider may only bill for NMT if that provider is a certified NMT provider. .

   b. LST may be delivered during the provision of services by behavioral line staff only when directly authorized by the Department.

3. LST does not include services offered under the State Plan or other resources.

4. LST does not include services offered through other waiver services, except those that are incidental to the LST training activities or purposes, or are incidentally provided to ensure the ~~client~~member's health and safety during the provision of LST.

C. PROVIDER QUALIFICATIONS

1. The provider agency furnishing services to waiver ~~client~~members shall abide by all general certification standards, conditions, and processes established for the ~~client~~member's respective waiver: HCBS-CMHS, -EBD, or -SCI waivers in Section 8.487; HCBS-SLS waiver in Section 8.500.98.

2. In accordance with 42 C.F.R Section 441.301(c)(1)(vi), providers of LST for the individual, or those who have an interest in or are employed by the provider of LST, must

not authorize services or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to authorize services and/or develop person-centered plans in a geographic area also provides HCBS.

3. The agency must employ an LST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, or a degree within a relevant field; and

4. The agency must ensure any component of the LST plan that may contain activities outside the scope of the LST trainer's expertise or licensure must be created by an appropriately licensed professional acting within his/her scope of practice.

    a. The professional must hold a license with no limitations in the scope of practice appropriate to meet the ~~client~~member's LST needs. The following licensed professionals are authorized to furnish LST training:

        i. Occupational Therapist;

        ii. Physical Therapist;

        iii. Registered Nurse;

        iv. Speech Language Pathologist;

        v. Psychologist;

        vi. Neuropsychologist;

        vii. Medical Doctor;

        viii. Licensed Clinical Social Worker

        ix. Licensed Professional Counselor; or

        x. Board Certified Behavior Analyst (BCBA)

    b. An appropriately licensed professional providing a component(s) of the LST plan may be an agency staff ~~client~~member~~member~~, contract staff ~~client~~member~~member~~, or external licensed and certified professionals who are fully aware of duties conducted by LST trainers.

5. An agency must maintain a Class A or B Home Care Agency License issued by the Colorado Department of Public Health and Environment if that agency chooses to provide training on Personal Care as defined in one of the following listed regulations: Personal Care in the HCBS-CMHS, -EBD, or -~~SCI~~ CIH waivers as defined at Section 8.489.10; Personal Care in the HCBS-SLS waiver as defined at Section 8.500.94.B.12.

6. The agency must employ one or more LST Trainers to directly support ~~client~~members, one-on-one, by designing with the ~~client~~member an individualized LST program service plan and implementing the plan for the ~~client~~member's training.

    a. An individual is qualified to be an LST trainer only if he/she is:

i. A licensed health care professional with experience in providing functionally based assessments and skills training for individuals with disabilities;

ii. An individual with a ~~Bachelor's~~bachelor's degree and 1 year of experience working with individuals with disabilities;

iii. An individual with an ~~Associate's~~associate degree in a social service or human relations area and 2 years of experience working with individuals with disabilities;

iv. An individual currently enrolled in a degree program directly related to special education, occupational therapy, therapeutic recreation, and/or teaching with at least 3 years of experience providing services similar to LST services;

v. An individual with 4 years direct care experience teaching or working with needs of individuals with disabilities; or

vi. An individual with 4 years of lived experience transferable to training designed and directed with the ~~client~~member~~member~~ to develop and maintain his/her ability to sustain himself/herself physically, emotionally, socially and economically in the community; and the provider must ensure that this individual receives ~~client~~member~~member~~-specific training sufficient to enable the individual to competently provide LST to the ~~client~~member consistent with the LST Plan and the overall Service Plan.

a) For anyone qualifying as a trainer under ~~this criteria~~these criteria, the provider must ensure that the trainer receives additional ~~client~~member~~member~~-specific training sufficient to enable him/her to competently provide LST to the ~~client~~member that is consistent with the LST Plan.

b. Prior to delivery of and reimbursement for any services, LST trainers must complete the following trainings:

i. Person-centered support approaches;

ii. HIPAA and ~~client~~member confidentiality;

iii. Basics of working with the population to be served;

iv. On-the-job coaching by the provider or an incumbent LST trainer on the provision of LST training;

v. Basic safety and de-escalation techniques;

vi. Community and public resource availability; and

vii. Recognizing emergencies and knowledge of emergency procedures including basic first aid, home and fire safety.

c. The provider must insure that staff acting as LST trainers receive ongoing training within 90 days of unsupervised contact with a ~~client~~member, and no less than once annually, in the following areas:

i. Cultural awareness;

ii. Updates on working with the population to be served; and

iii. Updates on resource availability.

d. The provider employing an LST Trainer must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment as an LST Trainer. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of ~~client~~members. All costs related to obtaining a criminal background check shall be borne by the provider.

D. PROVIDER RESPONSIBILITIES

1. Life Skills Training trainers directly support the ~~client~~member by designing with the ~~client~~member an individualized LST program service plan, and by implementing the plan through training with the ~~client~~member to develop and maintain his/her ability to independently sustain himself/herself physically, emotionally, socially and economically in the community.

2. The LST coordinator must review the ~~client~~member's LST program service plan to ensure it is designed to meet the needs of the ~~client~~member in order to enable him/her to independently sustain himself/herself physically, emotionally, and economically in the community; and

3. The LST coordinator must share the LST program service plan with the ~~client~~member's providers of other HCBS services that support or implement any LST services The LST coordinator will seek permission from the ~~client~~member prior to sharing the LST program service plan, or any portion of it, with other providers; and

4. Any component of the LST program service plan that may contain activities outside the scope of the LST trainer's scope of expertise or licensure must be created by the appropriately licensed professional within his/her scope of practice.

5. All LST program service plans containing any professional activity must be reviewed and authorized monthly during the service period, or as needed, by professionals responsible for oversight.

E. DOCUMENTATION

1. All LST providers must maintain a LST program service plan that includes:

a. Monthly skills training plans to be developed and documented; and

b. Skills training plans that include goals, goals achieved or failed, and progress made toward accomplishment of continuing goals.

All documentation, including, but not limited to, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to Section 8.130.2 and provided to supervisor(s),

program monitor(s), auditor(s), and CDPHE surveyor(s) upon request. The LST service plan must include:

i. The start and end time/duration of service provision;

ii. The nature and extent of service;

iii. A description of LST activities, such as accompanying ~~client~~members to complicated medical appointments or to attend board, advisory and commissions meetings; and support with interviewing potential providers;

iv. Progress toward Service Plan goals and objectives; and

v. The provider's signature and date.

2. The LST program service plan shall be sent to the Case Management Agency responsible for the Service Plan on a monthly basis, or as requested by the Case Management Agency.

3. The LST program service plan shall be shared, with the ~~client~~member's permission, with the ~~client~~member's providers of other HCBS services that support or implement any service inclusions of the ~~client~~member's LST program that meet the needs of the ~~client~~member, enabling him/her to independently sustain himself/herself physically, emotionally, socially, and economically in the community.

F. REIMBURSEMENT

1. LST may be billed in 15-minute units. ~~Client~~Members may utilize LST up to 24 units (six hours) per day, no more than 160 units (40 hours) per week, for up to 365 days following the first day the service is provided.

2. Payment for LST shall be the lower of the billed charges or the maximum rate of reimbursement.

3. LST may include escorting ~~client~~members if doing so is incidental to performing an authorized LST service. However, costs for transportation in addition to those for accompaniment may not be billed LST services. LST providers may furnish and bill separately for transportation, provided that they meet the state's provider qualifications for transportation services.

4. If accompaniment and transportation are provided through the same agency, the person providing transportation may not be the same person who provided accompaniment as a LST benefit to the ~~client~~member.

8.553.4 HOME DELIVERED MEALS

A. INCLUSIONS

1. Home Delivered Meals services ~~include::~~include:

a. Individualized nutritional counseling and developing an individualized Nutritional Meal Plan, which specifies the ~~client~~member's nutritional needs, selected meal types, and instructions for meal preparation and delivery; and

b. Services to implement the individualized meal plan, including the ~~client~~member's requirements for preparing and delivering the meals.

c. The ~~provision~~delivery of prepared nutritional meals.

B. SERVICE REQUIREMENTS

1. The ~~client~~member's Service Plan must specifically identify:

   a. the ~~client~~member's need for individualized nutritional counseling and development of a Nutritional Meal Plan, which describes the ~~client~~member's nutritional needs and selected meal types, and provides instructions for meal preparation and delivery; and

   b. the ~~client~~member's specifications for preparation and delivery of meals, and any other detail necessary to effectively implement the individualized meal plan.

2. The service must be provided in the home or community and in accordance with the ~~client~~member's Service Plan. All Home Delivered Meal services shall be documented in the Service Plan.

3. ~~Client~~Members may be approved for Home Delivered Meals for no more than 365 days.

4. Meals are to be delivered up to two meals per day, with a maximum of 14 meals delivered per week.

5. Meals may include liquid, mechanical soft, or other medically necessary types.

6. Meals may be ethnically or culturally-tailored.

7. Meals may be delivered hot, cold, frozen, or shelf-stable, depending on the ~~client~~member's or caregiver's ability to complete the preparation of, and properly store the meal.

8. The provider shall confirm meal delivery to ensure the ~~client~~member receives the meal in a timely fashion, and to determine whether the ~~client~~member is satisfied with the quality of the meal.

9. The providing agency's certified RD or RDN will check in with the ~~client~~member no less frequently than every 90 days to ensure the meals are satisfactory, that they promote the ~~client~~member's health, and that the service is meeting the ~~client~~member's needs.

10. The RD or RDN will review ~~client~~member's progress toward the nutritional goal(s) outlined in the ~~client~~member's Service Plan no less frequently than once per calendar quarter, and more frequently, as needed.

11. The RD or RDN shall make changes to the Nutritional Meal Plan if the quarterly assessment results show changes are necessary or appropriate.

12. The RD or RDN will send the Nutritional Meal Plan to the Case Management Agency no less frequently than once per quarter to allow the Case Management Agency to verify the plan with the ~~client~~member during the quarterly check-in, and to make corresponding updates to the Person-Centered Service plan, as needed.

C. LIMITATIONS AND EXCLUSIONS

1. Home Delivered Meals are not available when the ~~client~~member resides in a provider-owned or controlled setting.

2. Delivery must not constitute a full nutritional regimen; and includes no more than two meals per day or 14 meals per week.

3. If ~~I~~items or services through which the ~~client~~member's need for Home Delivered Meal services can otherwise be met, including any item or service available under the State Plan, applicable HCBS waiver, or other resources are excluded.

4. Meals not identified in the Nutritional Meal Plan or any item outside of the meals not identified in the meal plan, such as additional food items or cooking appliances are excluded.

5. Meal plans and meals provided are reimbursable when they benefit of the ~~client~~member, only. Services provided to someone other than the ~~client~~member are not reimbursable.

D. PROVIDER STANDARDS

1. A licensed provider enrolled with Colorado Medicaid to provide Home Delivered Meal services ~~M~~must be a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and holding a Certificate of Good Standing to do business in Colorado.

2. Must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, ~~-~~ EBD, BI, or ~~-SCI~~CIH waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98.

3. ~~Must hold a Retail Food license, and must maintain Food Handling licenses for staff delivering meals. All licenses must be current, with no limitations.~~The provider shall ~~have~~maintain ~~all licenses~~licensure as required by the State of Colorado Department of Public Health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for staff; or be approved by Medicaid as a home delivered meals provider in their home state.

4. Must maintain a Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN) on staff or under contract.

5. In accordance with 42 C.F.R Section 441.301(c)(1)(vi), providers of Home Delivered Meals for the individual, or those who have an interest in or are employed by the provider of Home Delivered Meals for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

6. The provider furnishing Home Delivered Meals services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment who would be tasked with furnishing Home Delivered Meals services. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of ~~client~~members. All costs related to obtaining a criminal background check shall be borne by the provider.

E. DOCUMENTATION

1. The provider shall maintain documentation in accordance with Section 8.130 and shall provide documentation to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request. Required documentation includes:

   a. Documentation pertaining to the provider agency, including employee files, claim submission documents, program and financial records, insurance policies, and licenses, including a Retail Food License and Food Handling License for Staff, or, if otherwise applicable, documentation of compliance and good standing with the City and County municipality in which this service is provided; and

   b. Documentation pertaining to services, including:

      i. A Signed authorization from appropriate licensed professional for dietary restrictions or specific nutritional needs;

      ii. ~~Client~~Member demographic information;

      iii. A Meal Delivery Schedule;

      iv. Documentation of special diet requirements;

      v. A determination of the type of meal to be provided (e.g. hot, cold, frozen, shelf stable);

      vi. A record of the date(s) and place(s) of service delivery;

      vii. Monitoring and follow-up (contacting the ~~client~~member after meal deliver to ensure the ~~client~~member is satisfied with the meal); and

      viii. Provision of nutrition counseling.

F. REIMBURSEMENT

1. Home Delivered Meals services are reimbursed based on the number of units of service provided, with one unit equal to one meal.

2. Payment for Home Delivered Meals shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the Service Plan.

8.553.5 PEER MENTORSHIP

A. INCLUSIONS

1. Peer Mentorship means support provided by peers of the ~~client~~member on matters of community living, including:

   a. Problem-solving issues drawing from shared experience.

   b. Goal Setting, self-advocacy, community acclimation and integration techniques.

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

d. Activities that promote interaction with friends and companions of choice.

e. Teaching and modeling of social skills, communication, group interaction, and collaboration.

f. Developing community-~~client~~member relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests.

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

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

i. Assisting ~~client~~members to be aware of and engage in community resources.

B. LIMITATIONS AND EXCLUSIONS

1. ~~Client~~Members may utilize Peer Mentorship up to 24 units (six hours) per day, for no more than 160 units (40 hours) per week, for no more than 365-days.

2. Services covered under the State Plan, another waiver service, or by other resources are excluded.

3. Services or activities that are solely diversional or recreational in nature are excluded.

C. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Peer Mentorship services if:

a. The provider is a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State and holding a Certificate of Good Standing to do business in Colorado;

b. The provider conforms to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, -BI, or -SCI waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98;

c. The provider ~~has a~~ is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the provider's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; and

d. The provider cooperates with CDPHE compliance and complaint surveys, and obeys all CDPHE policies, regulations and directives regarding licensure.

e. In accord with 42 CFR 441.301(c)(1)(vi), providers of Peer Mentorship for the individual, or those who have an interest in or are employed by the provider of Peer Mentorship for the individual, must not provide case management, authorize services, or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management, authorize services, and/or develop person-centered service plans in a geographic area also provides HCBS.

f. Peer Mentorship shall not be provided by a peer who receives programming from the same residential location, day program location, or employment location as the ~~client~~member.

2. The provider must ensure services are delivered by a peer mentor staff who:

a. Has lived experience transferable to support a ~~client~~member~~member~~ with acclimating to community living through providing them ~~client~~member~~member~~ advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the ~~client~~member~~member~~'s self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

b. Is qualified to furnish the services customized to meet the needs of the ~~client~~member as described in the Service Plan;

c. Does not receive programming from the same residential location or day program location as the ~~client~~member; and

d. Has completed training from the provider agency consistent with core competencies ~~and training standards presented to agencies by the Department at Peer Mentorship provider agency training~~. Core competencies are:

i. Understanding boundaries;

ii. Setting and pursuing goals;

iii. Advocacy for Independence Mindset;

iv. Understanding of Disabilities, both visible and non-visible, and how they intersect with identity; and

v. Person-Centeredness.

3. The provider of peer mentorship services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment as a Peer Mentor, and on all staff who interface with Medicaid ~~client~~members. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of ~~client~~members. All costs related to obtaining a criminal background check shall be borne by the provider.

4. The provider must ensure that no staff member~~client~~~~member~~ having contact with ~~client~~members is substantiated in the Colorado Adult Protection Services (CAPS) registry for mistreatment of an at-risk adult.

D. DOCUMENTATION

1. All documentation, including but not limited to, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to Section 8.130.2 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request, including:

   a. Start and end time/duration of services;

   b. Nature and extent of services;

   c. Mode of contact (face-to-face, telephone, other);

   d. Description of peer mentorship activities such as accompanying ~~client~~member<u>s</u> to complicated medical appointments or to attend board, advisory and commissions meetings, and support provided interviewing potential providers;

   e. ~~Client~~Member's Response as outlined in the Peer Mentorship Manual;

   f. Progress toward Service Plan goals and objectives; and

   g. Provider's signature and date.

E. REIMBURSEMENT

1. Peer Mentorship services are reimbursed based on the number of units billed, with one unit equal to 15 minutes of service.

2. Payment for Peer Mentorship shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the Service Plan

8.553.6 TRANSITION SETUP

A. SERVICE ACCESS AND AUTHORIZATION

1. To access Transition Setup, defined in Section 8.553.1, a ~~client~~member must be transitioning from an institutional setting to a community living arrangement and participate in a ~~needs based~~needs-based assessment through which they demonstrate a need for the service based on the following:

   a. The ~~client~~member demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a ~~client~~member to establish a basic household in the community;

   b. The need demonstrates risk to the ~~client~~member's health, safety, or ability to live in the community.

   c. Other services/resources to meet need are not available.

2. The ~~client~~member's assessed need must be documented in the ~~client~~member's Transition Plan and Service Plan.

3. Transition Setup is available in the Department's HCBS-BI Waiver under the Department's rule Section 8.515.2.A.17; HCBS-CMHS Waiver under the Department's rule Section 8.509.12.A.13; HCBS-DD Waiver under Section 8.500.5.A.10; HCBS-EBD Waiver under Section 8.485.31.N; HCBS-~~SCI~~ CIH Waiver under Section 8.517.1.A.14; and HCBS-SLS Waiver under Section 8.500.94.A.~~24~~20.

B. INCLUSIONS

1. Transition Setup assists the ~~client~~member by coordinating the purchase of items or services needed to establish a basic household and to ensure the home environment is ready for move-in with all applicable furnishings set up and operable; and

2. Transition Setup covers the purchase of one-time, non-recurring expenses necessary for a ~~client~~member to establish a basic household as they transition from an institutional setting to a community setting. Allowable expenses include:

   a. Security deposits that are required to obtain a lease on an apartment or home.

   b. Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).

   c. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.

   d. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.

   e. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.

   f. Housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal background check.

C. LIMITATIONS AND EXCLUSIONS

1. Transition Setup may be used to coordinate or purchase one-time, non-recurring expenses up to 30 days post-transition.

2. Transition Setup expenses must not exceed a total of $1,500 per eligible ~~client~~member~~member~~. The Department may authorize additional funds above the $1,500 limit, not to exceed a total value of $2,000, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the ~~client~~member~~member~~.

3. Transition Setup does to substitute services available under the Medicaid State Plan, other waiver services, or other resources.

4. Transition Setup is not available for a transition to a living arrangement that is owned or leased by a waiver provider if the services offered as Transition Setup benefits are services furnished under the waiver.

5. Transition Setup does not include payment for room and board.

6. Transition Setup does not include rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes.

7. Transition Setup is not available for a transition to a living arrangement that does not match or exceed HUD certification criteria.

8. Transition Setup is not available when the person resides in a provider-owned or -controlled setting.

9. Transition Setup does not include appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television or video equipment, cable or satellite service, computers or tablets).

D. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Transition Setup services if:

   a. The provider is a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and holding a Certificate of Good Standing to do business in Colorado; and

   b. The provider is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations.

2. The provider must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, -BI, or -~~SCI~~ CIH waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98; and

3. In accord with 42 C.F.R Section 441.301(c)(1)(vi), providers of Transition Setup for the individual, or those who have an interest in or are employed by the provider of Transition Setup for the individual, must not provide case management, authorize services, or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management, authorize services, and/or develop person-centered service plans in a geographic area also provides HCBS.

4. The provider of Transition Setup services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment that would involve direct contact with Medicaid ~~client~~member s. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of ~~client~~member s. All costs related to obtaining a criminal background check shall be borne by the provider.

5. The provider shall ensure the product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

E. DOCUMENTATION

1. The provider must maintain receipts for all services and/or items procured for the ~~client~~member. These must be attached to the claim and noted on the Prior Authorization Request.

2. Providers must submit to the Case Management Agency the minimum documentation of the transition process, which includes:

   a. A Transition Services Referral Form,

   b. Release of Information (confidentiality) Forms, and

   c. A Transition Setup Authorization Request Form.

3. The provider must furnish to the ~~client~~member a receipt for any services or durable goods purchased on the ~~client~~member's behalf.

F. REIMBURSEMENT

1. Transition Setup coordination is reimbursed according to the number of units billed, with one unit equal to 15-minutes of service. The maximum number of Transition Setup units eligible for reimbursement is 40 units per eligible ~~client~~member.

2. Transition Setup expenses must not exceed $1,500 per eligible ~~client~~member. The Department may authorize additional funds above the $1,500 limit, up to $2,000, when the ~~client~~member demonstrates additional needs, and if the expense(s) would ensure the ~~client~~member's health, safety and welfare.

3. Payment for Transition Setup shall be the lower of the billed charges or the maximum rate of reimbursement.

4. Reimbursement shall be made only for items or services described in the Service plan with an accompanying receipt.

5. When Transition Setup is furnished to individuals returning to the community from an institutional setting through enrollment in a waiver, the costs of such services are billable when the person leaves the institutional setting and is enrolled in the waiver.

8.553.7 HOME DELIVERED MEALS POST-HOSPITAL DISCHARGE

A. INCLUSIONS

1. Home Delivered Meals services include:

   a. Individualized nutritional counseling and developing an individualized Nutritional Meal Plan, which specifies the ~~client~~member's nutritional needs, selected meal types, and instructions for meal preparation and delivery; and

   b. Services to implement the individualized meal plan, including the ~~client~~member's requirements for preparing and delivering the meals.

   c. The ~~provision~~delivery of prepared nutritional meals.

   ~~i. Nutritional Counseling and Nutritional Meal Plan may be opted out based on member choice.~~

B. SERVICE REQUIREMENTS

1. The ~~client~~member's Service Plan must specifically identify:

   a. T~~t~~he ~~client~~member's need for individualized nutritional counseling and development of a Nutritional Meal Plan, which describes the ~~client~~member's nutritional needs and selected meal types, and provides instructions for meal preparation and delivery; and

   b. T~~t~~he ~~client~~member's specifications for preparation and delivery of meals, and any other details necessary to effectively implement the individualized meal plan.

2. The service must be provided in the home or community and in accordance with the ~~client~~member's Service Plan. All Home Delivered Meal services shall be documented in the Service Plan.

3. ~~Client~~Members may be approved for Home Delivered Meals for no more than 30 days post qualifying hospital discharge. Benefit may be accessed for no more than two 30-day periods during a ~~client~~member's certification period.

   ~~a. Member may request one meal per day, based on choice~~

4. Meals are to be delivered up to two meals per day, with a maximum of 14 meals delivered per week.

5. Meals may include liquid, mechanical soft, or other medically necessary types.

6. Meals may be ethnically or culturally-tailored.

7. Meals may be delivered hot, cold, frozen, or shelf-stable, depending on the ~~client~~member's or caregiver's ability to complete the preparation of, and properly store the meal.

8. The provider shall confirm meal delivery to ensure the ~~client~~member receives the meal in a timely fashion, and to determine whether the ~~client~~member is satisfied with the quality of the meal.

C. LIMITATIONS AND EXCLUSIONS

1. Home Delivered Meals are not available when the ~~client~~member resides in a provider-owned or controlled setting.

2. Delivery must not constitute a full nutritional regimen; and includes no more than two meals per day or 14 meals per week, for a maxiumum of 30 days.

3. Items or services through which the ~~client~~member's need for Home Delivered Meal services can otherwise be met, including any item or service available under the State Plan, applicable HCBS waiver, or other resources are excluded.

4. Meals not identified in the Nutritional Meal Plan or any item outside of the meals not identified in the meal plan, such as additional food items or cooking appliances are excluded.

5. Meal plans and meals provided are reimbursable when they benefit of the ~~client~~member, only. Services provided to someone other than the ~~client~~member are not reimbursable.

D. PROVIDER STANDARDS

1. A licensed provider enrolled with Colorado Medicaid to provide Home Delivered Meal services mMust be a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and holding a Certificate of Good Standing to do business in Colorado.

2. Must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, BI, or -CIH waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98.

3. The provider shall have all licenses required by the State of Colorado Department of Public Health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for staff; or be approved by Medicaid as a home delivered meals provider in their home state.

4. Must maintain a Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN) on staff or under contract.

5. In accordance with 42 C.F.R Section 441.301(c)(1)(vi), providers of Home Delivered Meals for the individual, or those who have an interest in or are employed by the provider of Home Delivered Meals for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

6. The provider furnishing Home Delivered Meals services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment who would be tasked with furnishing Home Delivered Meals services. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of ~~client~~members. All costs related to obtaining a criminal background check shall be borne by the provider.

E. DOCUMENTATION

1. The provider shall maintain documentation in accordance with Section 8.130 and shall provide documentation to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request. Required documentation includes:

   a. Documentation pertaining to the provider agency, including employee files, claim submission documents, program and financial records, insurance policies, and licenses, including a Retail Food License and Food Handling License for Staff, or, if otherwise applicable, documentation of compliance and good standing with the City and County municipality in which this service is provided; and

   b. Documentation pertaining to services, including:

      i. A Signed authorization from appropriate licensed professional for dietary restrictions or specific nutritional needs;

      ii. ~~Client~~Member demographic information;

      iii. A Meal Delivery Schedule;

iv. Documentation of special diet requirements;

v. A determination of the type of meal to be provided (e.g. hot, cold, frozen, shelf stable);

vi. A record of the date(s) and place(s) of service delivery, including person delivering the meal;

vii. Monitoring and follow-up (contacting the ~~client~~member after meal deliver to ensure the ~~client~~member is satisfied with the meal); and

viii. Provision of nutrition counseling or documentation of ~~client~~member declination.

F. REIMBURSEMENT

1. Home Delivered Meals services are reimbursed based on the number of units of service provided, with one unit equal to one meal.

2. Payment for Home Delivered Meals shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the Service Plan.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Supports Intensity Scale Assessment, Section 8.612
Rule Number: MSB 22-10-04-A
Division / Contact / Phone: Office of Community Living / Mariah Kohlruss-Ecker / 303-866-5773

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: Revision to the Medical Assistance Act Rule concerning the Supports Intensity Scale Assessment, Section 8.612. **MSB 22-10-04-A.**
The final rules around the Supports Intensity Scale Assessment and Support Levels, 10 C.C.R 2505-10 Section 8.612 are being revised in order to create more equity, transparency, be more person-centered, and to be responsive to recent stakeholder engagement and concerns brought to the Department's attention. The revised rules include Sections 8.612.1 Supports Intensity Scale (SIS) Assessment, 8.612.2 SIS Complaint Process, 8.612.3 Support Levels, and 8.612.4 Support Level Review Process as well as the addition of Section 8.612.5 Definitions.

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

   Sections(s) 8.612, 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 8.612 with the proposed text beginning at 8.612.1 through the end of 8.612.5. This rule is effective April 14, 2023.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning the Supports Intensity Scale Assessment, Section 8.612
Rule Number: MSB 22-10-04-A
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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 Supports Intensity Scale (SIS) Assessment is used to measure the intensity of support needed for individuals with Intellectual and Developmental Disabilities (I/DD) to be successful in all aspects of their daily life. The Support Level algorithm is a resource allocation methodology used by the Department for all individuals with Intellectual and Developmental Disabilities seeking or receiving Home and Community Based Services (HCBS) Supported Living Services (SLS) Waiver and Developmental Disabilities (DD) Waiver services. This rule defines the Support Level algorithm and all processes used to determine Support Levels and exceptions processes which impact the funding associated to the delivery of those services.

   The proposed rule changes are necessary to be responsive to stakeholder input regarding SIS Assessment outcome notification, Person-Centered Support Planning processes, and exceptions processes related to Safety Risk Factors.

   Specifically, the problems with the current rule are that there is permissive rather than directive language for the Case Management Agencies (CMAs) to provide a copy of the SIS results to Members. There is also currently no requirement for the SIS Assessment results to be reviewed at the Person-Centered Support Planning meeting. Additionally, the Support Level algorithm table does not accurately reflect "floors" and "ceilings" in the algorithm formulas. Lastly, the steps outlined in rule to address Safety Risk Factors and their impact on the Support Levels is currently not sufficient to detail the processes that Members and CMAs may undertake to transition Members safely and effectively from more "controlled" environments and supervision levels to more independent living in their communities. The Department has received specific case examples of Members who have had their provider terminate or threaten to terminate services based on an abrupt Support Level decrease due to the Member no longer meeting the Safety Risk definition, which then causes a negative ripple effect for that Member. This sudden change and negative ripple effect can be extremely jarring for the Member. This illustrates the need for rule revisions to allow for a more gradual, step-down process in which the Member is supported to progressively gain more independence as situations warrant.

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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. (2022);

   Section 25.5-6-404 (2022)

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Title of Rule: Revision to the Medical Assistance Act Rule concerning the Supports Intensity Scale Assessment, Section 8.612
Rule Number: MSB 22-10-04-A
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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.

   Health First Colorado Members with Intellectual and Developmental Disabilities (I/DD) who are seeking or receiving Home and Community Based Services (HCBS) Supported Living Services (SLS) or Developmental Disabilities (DD) Waivers serving adults are the class of persons who will be affected by the proposed rule. These same Members will benefit from these amendments to the rule. Especially positively affected will be those Members who do not have family or advocates to speak on their behalf, because this rule will require that all Members be provided pertinent Supports Intensity Scale (SIS) and Support Level (SL) information automatically and equitably.

   There is not a class of persons receiving services that will bear any costs of the amended rule. The Department is working to streamline Case Management Agency (CMA) processes so as to mitigate any potential costs associated with these changes. The Department may bear increased costs for the slower transitions but expects those costs to be offset by reduced recurrence of safety risks.

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

   The qualitative impact of the proposed rule is that affected Members with Intellectual and Developmental Disabilities (I/DD) and their guardians/family members will experience more transparency, equitability in communication processes, and increased person-centeredness in the outcomes related to the SIS Assessment and Support Level processes. There is not a means to quantify this experience for Members.

   The Department anticipates that by the development of a more gradual step-down process for Members who have additional Safety Risk Factors, Members should experience a safer transition to more independent living, thereby reducing recurrence of safety issues and consequent increases of care leading to potential longer-term costs without these new processes in place.

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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.

   Because this rule amendment includes additional steps that Case Management Agencies (CMA) who serve Members with Intellectual and Developmental Disabilities (I/DD) must complete in order to increase transparency and communication efforts, there could be associated costs to the Department and the CMAs under contract with the Department. The Department is working with the CMAs to create efficient practices which streamline all SIS-related communication, tracking, and follow-up to mitigate workload issues and thus avoid additional associated costs.

   While there are potential increased costs to the Department with these slower transitions, the avoidance of the "cliff" from a higher Support Level to an abrupt low Support Level, may offset additional costs by avoiding recurring Safety Risks resulting in increased care needs. The short-term transitional cost invests in the longer-term success of Member's independence in community life.

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

   The probable increased costs to both the CMAs and the Department are outweighed by the significant benefit to Members and the efficiencies that can be gained when support teams are fully informed of Members' needs going into the support-planning process. There are also gains to be made when assisting Members to transition from higher Support Levels and intrusiveness of services into more independent, community connected lives, thereby likely driving down long-term service costs.

   CMAs and the Department may accrue minimal training costs initially, and there may be costs associated with maintaining Members at higher Support Levels during transitions in restoring their rights around "controlled" environments and/or line of sight supervision levels. It is probable that the gradual transitions may help avoid some of the current costs for an increase in acuity following the funding "cliff". While not passing the rule change would avoid the upfront costs described above, Members would continue to struggle with a lack of transparency and equity in access to communications around exceptions processes and will continue to struggle with abrupt changes in services and funding. Further, by continuing to insufficiently support members to gradually adjust to lower levels of services and funding, the Department will continue to bear costs associated with additional safety risks.

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

The Department worked with stakeholder groups to determine the most optimal methods for achieving the purpose of the proposed rule and this approach was deemed the least costly and least intrusive of all options.

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 considered not requiring CMAs to provide a copy of the SIS Assessment Results to Members and relying on the existing method of only "upon request" (by the Member/guardian). This was deemed as ineffective and inequitable because not all Members have adequate access, voice, or advocates to routinely request a copy of their SIS Assessment results.

   Similarly, the Department considered not requiring CMAs to provide an overview of the results of the SIS Assessment at the Initial and/or Continued Stay Review service planning meeting. This was deemed to be inadequate because the Member and their support team need information upon which to make decisions and prioritize services in the person-centered support planning meeting.

   Additionally, the revisions that outline the process to be used to transition a Member from a higher Support Level who no longer meets the definition for Safety Risks was not clear and thus Members and the providers who serve them could unnecessarily experience a "cliff" in losing valuable services during this "step-down/transition" period in their lives.

8.612 SUPPORTS INTENSITY SCALE ASSESSMENT AND SUPPORT LEVELS

8.612.1 Supports Intensity Scale (SIS) Assessment [Eff. 2/1/12]

A. Completion of a Supports Intensity Scale (SIS) Assessment is a requirement for a ~~Client~~Member to participate in the Home and Community Based Services-Supported Living Services (HCBS-SLS) or the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver. A ~~Client~~Member, ~~his or her~~their ~~guardian~~legal guardian, or their legally authorized representative refusing to have a SIS assessment shall not be enrolled in the HCBS-SLS or HCBS-DD waivers.

B. Specific scores from the ~~Client~~Member's SIS assessment shall be used in addition to Risk Factor scores ~~other additional factors~~ to obtain the ~~Client~~Member's Support Level in the HCBS-DD and HCBS-SLS waivers.

C. The ~~Community Centered Board (CCB)~~Case Management Agency (CMA) shall conduct a SIS assessment for a ~~Client~~Member at the time of enrollment. ~~Additional~~ Reassessments ~~will~~shall be conducted ~~at a frequency determined~~upon approval by the Department.

D. The CMA~~CCB~~ shall:

1. Notify the ~~Client~~Member, ~~his or her~~their legal guardian, or their legally authorized representative ~~, or family member, as appropriate,~~ of the requirement for and the right to participate in the SIS assessment.

2. Support and encourage the ~~Client~~Member to participate in the SIS assessment. If the ~~Client~~Member chooses not to participate in the SIS assessment, the CMA shall document ~~his or her~~their choice in the ~~Client~~Member record on the Department required data system.

3. Schedule a SIS Interviewer to conduct the assessment. If the ~~Client~~Member, ~~his or her~~their legal guardian, or their legally authorized representative~~, or family member, as appropriate,~~ objects to the assigned SIS Interviewer, they ~~he or she~~ shall be offered a choice of a different SIS Interviewer.

4. Assist the ~~Client~~Member or other interdisciplinary team (IDT) members to identify at least two people who know the ~~Client~~Member well enough to act as respondents for the SIS assessment. If at least two respondents cannot be identified, the CMA shall document the efforts to find two respondents and the reasons this could not be done and proceed with the assessment using the information available.

5. ~~Upon Department approval~~ To facilitate person centered practices, ~~The~~the ~~,~~ SIS assessment may be completed by the ~~case manager~~SIS Interviewer at an alternate location, via the telephone or using virtual technology methods. When practicable the Member's preference of engagement ~~the Member~~ shall be accommodated. ~~Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).~~

E. A qualified SIS Interviewer shall conduct the assessment. A SIS Interviewer shall not act as the respondent for a SIS assessment.

F. The ~~CCB~~CMA shall inform the ~~Client~~Member, ~~his or her~~their legal guardian, or their legally authorized representative~~, or family member, as appropriate,~~ of the purpose of the SIS, the SIS

Complaint Process, and the Support Level Review Process.~~,~~ The CMA shall document that this information was provided and received on the SIS and Support Level disclosure form. The CMA shall inform the Member ~~and~~ that ~~he or she~~ they will ~~shall~~ ~~may~~ receive a copy of the completed SIS assessment within 30 days of the SIS ~~i~~Interview date ~~upon request~~. The CMA~~CCB~~ shall document provision of a copy of the SIS assessment to the Member, their guardian, or their legally authorized representative in the Department prescribed system. ~~that this information was provided and received on the SIS and Support Level disclosure form.~~

1. The CMA case manager will provide an overview of the results of the most recent SIS assessment during the initial or continued stay review (CSR) person-centered support planning process. This overview shall include discussion of:

   a. The E~~e~~xceptional M~~m~~edical and/or B~~b~~ehavioral S~~s~~upport N~~n~~eeds identified in Section 1 of the SIS assessment;

   b. The areas of priority support needs identified in Section 2 of the SIS assessment;

   c. The resulting Support Level; and,

   d. The services necessary to meet these priority areas.

2. If, upon review of the results of the SIS assessment at the initial or CSR planning meeting, there is a significant change in the Member's condition or circumstances, they should refer to G. below for the SIS reassessment process or Section 8.612.4 Support Level Review Process

G. After the initial SIS assessment has been completed, the CMA shall conduct a ~~nother~~ SIS reassessment for the ~~Client~~Member only when approved by the Department through the following process:

1. Prior to a ~~subsequent~~ SIS reassessment being conducted, the CMA shall submit a request to the Department for approval in the format prescribed by the Department.

2. The Department shall provide the CMA with a written decision regarding the request to conduct a ~~another~~ SIS reassessment within fifteen (15) business days after the date the request was received.

3. Upon receiving approval to conduct a ~~subsequent~~ SIS reassessment, the CMA shall coordinate with a SIS Interviewer to complete the SIS reassessment. ~~contact the designated CCB to request a SIS reassessment~~.

4. If the ~~Client~~Member, ~~his or her~~their legal guardian, or their legally authorized representative ~~or family member, as appropriate,~~ disagrees with a decision to deny the ~~the~~ SIS reassessment request ~~decision~~, then a request for review of the decision may be submitted to the Executive Director of the Department, or their designee, within fifteen (15) business days after the date the decision was received.

5. The Department's Executive Director, or ~~his or her~~their designee, shall review the request for conducting a SIS reassessment and provide a written decision within fifteen (15) business days of the receipt of the request for the Executive Director review.

6. The decision of the Department's Executive Director, or ~~his or her~~their designee, shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.

H. A ~~subsequent~~ SIS reassessment shall be conducted only when approved by the Department and when:

1. There has been a change in the ~~Client~~Member's life circumstances or condition resulting in a significant change to the amount of services and supports needed to keep the ~~Client~~Member safe;

2. The ~~Client~~Member, ~~or his or her~~their legal guardian, or their legally authorized representative, family member or case manager, as appropriate, has reason to believe ~~that~~ the results of the most recent SIS assessment do not accurately reflect ~~his or her~~~~their~~ the Member's current support needs; or,

3. The Member, their legal guardian, or their legally authorized representative file a complaint, as outlined in 8.612.2, regarding the administration of the SIS assessment. ~~The Department deems it necessary to complete a new assessment in order to ensure its accuracy.~~

I. Administration of the SIS assessments shall be reviewed by the Department for the purpose of quality assurance.

J. When the Department identifies SIS Interviewer practices that result in inaccurate SIS assessments:

1. Remediation efforts by the Department may occur to ensure that the SIS Interviewer performs assessments according to Department standards. The SIS Interviewer(s) who conducted the inaccurate SIS assessment(s) may be deemed no longer qualified to conduct SIS assessments.

2. Payments made for the administration of the inaccurate SIS assessments may be recovered through a repayment agreement; by offsetting the amount owed against current and future SIS determination payments; or, by any other appropriate action within the Department's legal authority.

3. The ~~Client~~Member shall receive another SIS assessment conducted by a SIS Interviewer designated by the Department.

4. The ~~Client~~Member's Support Level and Service Plan Authorization Limit will be adjusted as necessary and effective on the date determined by the Department.

8.612.2 SIS Complaint Process [Eff. 2/1/12]

A. The ~~Client~~Member, ~~his or her~~their legal guardian, or their legally authorized representative ~~, or family member as appropriate,~~ may file a complaint regarding the administration of the SIS assessment up to thirty (30) calendar days after the SIS assessment is conducted.

B. The complaint shall be filed verbally or in writing with the ~~Client~~Member's ~~CCB~~CMA. Additional information to support the complaint may be submitted at that time. If the complaint has been filed verbally the CMA shall document in the ~~Client~~Member's record on the Department required data system the time, date and details surrounding the complaint.

C. When the complainant~~t~~ requests that another SIS assessment be completed, the ~~CCB~~CMA shall submit a request for approval to conduct another SIS assessment, pursuant to the process identified in Section 8.612.1.G.

D. The ~~CCB~~CMA shall make efforts to resolve the complaint and provide the complainant with a written response within ten (10) business days after receipt of the complaint.

E. When a resolution cannot be reached, the ~~CCB~~CMA shall inform the complainant that they ~~he or she~~ may submit the complaint to the Department within ~~fifteen (15) business days~~thirty (30) calendar days after receipt of the ~~CCB~~CMA response.

F. The Department shall provide a written response to the complainant within fifteen (15) business days after receipt of the complaint.

8.612.3 Support Levels [Eff. 2/1/12]

A. A ~~Client~~Member is assigned into one of six Support Levels according to ~~his or her~~their overall support needs and based upon the standardized algorithm for the HCBS-DD or HCBS-SLS waivers. The SIS-A Assessment converts subscale raw scores for each section into standard scores for each section, which are used in the algorithm for support levels. ~~Additional information can be found on the Department's webpage or can be obtained in writing by requesting from the Department.~~

B. The structure of the algorithm, defined at Section 8.600.4 definitions, includes the following:

1. Algorithm factors:

   a. Standard scores from Section 2: Parts A (Home Living Activities), B (Community Living Activities), and E (Health and Safety Activities) (ABE) from the SIS assessment;

   b. Total scores from Section 1A: Exceptional M~~m~~edial S~~s~~upport N~~n~~eeds score from the SIS assessment;

   c Total scores from Section 1B: E~~e~~xceptional B~~b~~ehavioral S~~s~~upport N~~n~~eeds score from the SIS assessment; and,

   d. Whether the ~~Client~~Member presents as a safety risk, defined at Section 8.600.4 definitions, as follows:

      1) In the HCBS-SLS waiver, Public Safety Risk-Convicted.

      2) In the HCBS-DD waiver, Public Safety Risk-Convicted/Not Convicted or Extreme Safety Risk to Self.

2. The subgroups in the algorithm table under each S~~s~~upport ~~l~~Level reflect variations of the intensity of the ~~Client~~Member's basic ~~support,~~ medical ~~support,~~ and behavioral support needs; no matter which subgroup a ~~Client~~Member falls into, they are ~~he or she is~~ eligible for that S~~s~~upport L~~l~~evel. The subgroups cluster individuals with similar behavioral and medical support needs within each major group. ~~Additional information can be found on the Department's website or can be obtained in writing by requesting from the Department.~~

3. Following an assessment of the factors defined above, standard scores for each factor are applied to the algorithm.

   The Support Level is determined when the scores for each factor meet all of the criteria of a S~~s~~upport L~~l~~evel subgroup.

4. The results of the algorithm are used to assign ~~Client~~Members to Ssupport Llevels one through six; with a Ssupport Llevel one indicating a minimal need for supports and a Ssupport Llevel six indicating a significantly higher need for supports.

5. For the HCBS-SLS waiver, the Ssupport Llevel determines the Service Plan Authorization Limit (SPAL), which is defined at Section 8.600.4 definitions. The SPALs are posted annually by the Department on the Department's webpage. ~~or available in writing by contacting the Department.~~

6. For the HCBS-DD waiver, the Ssupport Llevel determines the rate of reimbursement for the provider(s).

~~C. The formula for the algorithm is:~~**~~Support Level/Subgroup~~**
~~Support Level 1~~
~~Subgroup 1A: ABE < 25; 1A<1 AND 1B< 2~~
~~Subgroup 1B: ABE < 25; 1A< 2 AND 1B< 5~~
~~Subgroup 1C: ABE < 25; 1A<4 and 1B< 5~~
~~Support Level 2~~
~~Subgroup 2A: ABE 26-30; 1A<1 AND 1B<2~~
~~Subgroup 2B: ABE 26-30; 1A< 2 AND 1B< 5~~
~~Subgroup 2C: ABE 26-30; 1A<4 AND 1B< 5~~
~~Subgroup 1D: ABE < 25; 1A<6~~
~~Subgroup 1G: ABE < 25; 1B<9~~
~~Subgroup 2D: ABE 26-30; 1A<6~~
~~Subgroup 2G: ABE 26-30; 1B<9~~
~~Subgroup 3A: ABE 31-33; 1A< 1 AND 1B< 2~~
~~Subgroup 3B: ABE 31-33 1A< 2 AND 1B< 5~~
~~Support Level 3~~
~~Subgroup 1H: ABE < 25; 1B<13~~
~~Subgroup 2H: ABE 26-30; 1B<13~~
~~Subgroup 3C: ABE 31-33; 1A<4 AND 1B< 5~~
~~Subgroup 3D: ABE 31-33; 1A<6~~
~~Subgroup 3G: ABE 31-33; 1B<9~~
~~Subgroup 4A: ABE > 34; 1A< 1 AND 1B< 2~~
~~Subgroup 4B: ABE >34 1A< 2 AND 1B< 5~~
~~Support Level 4~~
~~Subgroup 1E: ABE < 25; 1A<8~~
~~Subgroup 1F: ABE < 25; 1A>9~~
~~Subgroup 1I: ABE < 25; 1B<15~~

~~Subgroup 1J: ABE < 25; 1B>16~~
~~Subgroup 2E: ABE 26-30; 1A<8~~
~~Subgroup 2I: ABE 26-30; 1B<15~~
~~Subgroup 2J: ABE 26-30; 1B>16~~
~~Subgroup 3E: ABE 31-33; 1A<8~~
~~Subgroup 3H: ABE 31-33; 1B<13~~
~~Subgroup 4C: ABE > 34; 1A<4 AND 1B< 5~~
~~Subgroup 4G: ABE > 34; 1B<9~~
~~**Support Level 5**~~
~~Subgroup 2F: ABE 26-30; 1A>9~~
~~Subgroup 3I: ABE 31-33; 1B<15~~
~~Subgroup 3J: ABE 31-33; 1B>16~~
~~Subgroup 4D: ABE >34; 1A<6~~
~~Subgroup 4E: ABE > 34; 1A<8~~
~~Subgroup 4H: ABE > 34; 1B<13~~
~~Subgroup 4I: ABE > 34; 1B<15~~
~~Group 5A: Community Safety (either status) AND 1b<11~~
~~**Support Level 6**~~
~~Subgroup 4J: ABE > 34; 1B>16~~
~~Group 6A: Community Safety (either status) AND 1b>12~~
~~Subgroup 3F: ABE 31-33; 1A>9~~
~~Subgroup 4F: ABE > 34; 1A>9~~
~~**Level 7**~~
~~Group 7: Individuals with Tier 7 Rates~~

~~Extreme Safety Risk to Self (as defined at Section 8.600.4 definitions) - This factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 3, level 2 increases to level 4, level 3 increases to level 4, level 4 increases to level 5. No change to levels 5 or 6, as this factor is already considered in the algorithm.~~

~~Public Safety Risk (as defined at Section 8.600.4 definitions) - this factor acts to increase the level~~

~~otherwise determined by the above criteria. Level 1 increases to level 5, level 2 increases to level 5, level 3 increases to level 5, and level 4 increases to level 6. No change to levels 5 or 6 as this factor is already considered in the algorithm.~~

~~Restoration of affected rights shall occur as soon as circumstances justify~~D. C. The CMA in ~~conjunction~~ consultation with the IDT shall make a determination whether a ~~Client~~ Member meets the definition of Public Safety Risk or Extreme Safety Risk to Self through the following process:

1. The decision shall be made by a case management supervisor. ~~He or she~~ They shall:

   a. Document the IDT discussion of the Rights Modification identifying the line of sight supervision and/or secured, controlled setting ~~environment rational~~ justification, ~~to support the decision which shall be kept~~ in the ~~Client~~ Member's record in the Department's prescribed system;

   b. Document that the ~~Client~~ Member meets the Public Safety Risk or Extreme Safety Risk to Self definition(s) in the Department prescribed ~~required~~ data system; and,

   c. Verify that the signed Informed Consent for the Rights Modification is in the Member's record in the Department's prescribed system.

2. The CMA shall r~~R~~eview the status of the ~~Client~~ Member's Safety Risk Factors at least annually or when significant changes occur, to assure that the Member~~Client~~ continues to meet the definition(s).

~~3.~~D. ~~At the point when a Client no longer meets the definition, his or her status must be changed in the Department required data system and his or her Support Level must be re-calculated.~~At the point when a Member no longer meets the definition(s) of Public Safety Risk or Extreme Safety Risk to Self ~~definition(s)~~, their status must be changed in the Department prescribed data system ~~and their Support Level must be re-calculated~~which will auto-calculate the Member's current algorithm Support Level and the Member's Person-Centered Support Plan (PCSP) shall be updated to reflect the removal of the Risk Factor and any changes in related, identified support needs within 10 business days of the definition(s) no longer being met or, in cases where Section 8.612.3.D.1-4~~C.3.a-b~~, applies, within 10 business days of receipt of approval or denial of the SLR request.

   ~~a~~1. For cases in which a Member's behavior does not satisfy a Safety Risk Factor definition but the Member's needs continue to be substantially higher than those typical of their assigned Support Level (without adjustments for risk factors) and a Rights Modification continues to be in place, the IDT may consider a Support Level Review (SLR) request, as outlined in 10 CCR 2505-10 8.612.4, as a part of the person-centered support planning and Rights Modification process.

   ~~b~~2. If the IDT determines a SLR request is needed, the CMA shall submit a SLR request which includes, but is not limited to, detailed information from the PCSP describing the extensive supports needed and the Rights Modification(s), to include all requirements outlined in Section 8.508.102 and Section 8.484.5.

   ~~c~~3. The Department shall review the SLR request as outlined in 10 CCR 2505-10 8.612.4.

   ~~d.~~4. Rights shall be restored as soon as circumstances justify.

~~i~~a. When rights are restored prior to the end date of the SLR approval period, the CMA shall notify the Department of the change in support needs in a manner determined by the Department.

~~ii~~b. When the right(s) are restored the Department shall adjust the Support Level override in the prescribed system ~~-~~to the original assessed algorithm Support Level.

~~iii~~c. ~~The CMA shall update the PCSP and authorization to reflect the changed support needs and Support Level in the Department prescribed data system within 10 business days of the Member's rights being restored.~~The CMA shall make any necessary PCSP and Prior Authorization (PAR) revisions resulting from the Support Level changes within ten (10) business days of the affected Support Level change.

~~D~~E~~E~~. The CMA shall inform each ~~Client~~Member, ~~his or her~~their legal guardian, or their legally authorized representative~~, or family member, as appropriate,~~ of ~~his or her~~their Support Level at the time of the initial or annual ~~Service Plan development~~ person-centered support planning process or when the Support Level changes for any reason.

~~F~~E~~F~~. Notification to the Member of a Support Level change shall occur within ~~ten (10)~~ twenty (20) business days of the date after the ~~Service Plan development or~~ Support Level change.

G. The Member shall be notified, pursuant to the Department of Health Care Policy and Financing rules in Section 8.057.2.A when a waiver service is terminated, reduced, or denied. At any time, the Member may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3.A.

~~G~~Each Support Level corresponds with the standardized reimbursement rates for individual waiver services and the Service Plan Authorization Limits (SPAL) in HCBS-SLS. H.~~F~~GH.In HCBS-DD, the Department may assign a Support Level seven (7) reimbursement rate for D~~d~~ay H~~h~~abilitation S~~s~~ervices and R~~r~~esidential H~~h~~abilitation S~~s~~ervices provided to a ~~Client~~Member with extraordinary ~~exceptional~~ overall needs in accordance with the Support Level Review Process.

~~G.HH~~I. The formula for the algorithm is:

Support Level/Subgroup
Support Level 1
Subgroup 1A: ∑ 2ABE ≤ 25; 1A ≤ 1 AND 1B ≤ 2
Subgroup 1B: ∑ 2ABE ≤ 25; 1A ≤ 2 AND 1B 3-5
Subgroup 1C: ∑ 2ABE ≤ 25; 1A 3-4 AND 1B 3-5
Support Level 2
Subgroup 2A: ∑ 2ABE 26-30; 1A ≤ 1 AND 1B ≤ 2
Subgroup 2B: ∑ 2ABE 26-30; 1A ≤ 2 AND 1B 3-5
Subgroup 2C: ∑ 2ABE 26-30; 1A 3-4 AND 1B 3-5

Subgroup 1D: ∑ 2ABE ≤ 25; 1A 5-6
Subgroup 1G: ∑ 2ABE ≤ 25; 1B 6-9
Subgroup 2D: ∑ 2ABE 26-30; 1A 5-6
Subgroup 2G: ∑ 2ABE 26-30; 1B 6-9
Subgroup 3A: ∑ 2ABE 31-33; 1A ≤ 1 AND 1B ≤ 2
Subgroup 3B: ∑ 2ABE 31-33 1A ≤ 2 AND 1B 3-5
Support Level 3
Subgroup 1H: ∑ 2ABE ≤ 25; 1B 10-13
Subgroup 2H: ∑ 2ABE 26-30; 1B 10-13
Subgroup 3C: ∑ 2ABE 31-33; 1A 3-4 AND 1B 3-5
Subgroup 3D: ∑ 2ABE 31-33; 1A 3-6
Subgroup 3G: ∑ 2ABE 31-33; 1B 6-9
Subgroup 4A: ∑ 2ABE ≥ 34; 1A ≤ 1 AND 1B ≤ 2
Subgroup 4B: ∑ 2ABE ≥ 34 1A ≤ 2 AND 1B 3-5
Support Level 4
Subgroup 1E: ∑ 2ABE ≤ 25; 1A 7-8
Subgroup 1F: ∑ 2ABE ≤ 25; 1A ≥ 9
Subgroup 1I: ∑ 2ABE ≤ 25; 1B 14-15
Subgroup 1J: ∑ 2ABE ≤ 25; 1B ≥ 16
Subgroup 2E: ∑ 2ABE 26-30; 1A 7-8
Subgroup 2I: ∑ 2ABE 26-30; 1B 14-15
Subgroup 2J: ∑ 2ABE 26-30; 1B ≥ 16
Subgroup 3E: ∑ 2ABE 31-33; 1A 7-8
Subgroup 3H: ∑ 2ABE 31-33; 1B 10-13
Subgroup 4C: ∑ 2ABE ≥ 34; 1A 3-4 AND 1B 3-5
Subgroup 4G: ∑ 2ABE ≥ 34; 1B 6-9
Support Level 5

Subgroup 2F: ∑ 2ABE 26-30; 1A ≥ 9
Subgroup 3I: ∑ 2ABE 31-33; 1B 14-15
Subgroup 3J: ∑ 2ABE 31-33; 1B ≥ 16
Subgroup 4D: ∑ 2ABE ≥ 34; 1A 3-6
Subgroup 4E: ∑ 2ABE ≥ 34; 1A 7-8
Subgroup 4H: ∑ 2ABE ≥ 34; 1B 10-13
Subgroup 4I: ∑ 2ABE ≥ 34; 1B 14-15
Group 5A: Public Safety Risk (either status) AND 1b ≤ 11
Support Level 6
Subgroup 4J: ∑ 2ABE ≥ 34; 1B ≥ 16
Subgroup 3F: ∑ 2ABE 31-33; 1A ≥ 9
Subgroup 4F: ∑ 2ABE ≥ 34; 1A ≥ 9
Group 6A: Extreme Safety Risk to Self AND Public Safety Risk (either status) AND 1b ≥ 12
Group 6B: Public Safety Risk (either status) AND 1b ≥ 12

Extreme Safety Risk to Self ~~(as defined at Section 8.600.4 definitions) –~~ this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 3, level 2 increases to level 4, level 3 increases to level 4, level 4 increases to level 5. Subgroup 6A outlines the conditions in which level 5 may increase to level 6.

Public Safety Risk ~~(as defined at Section 8.600.4 definitions) –~~ this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 5, level 2 increases to level 5, level 3 increases to level 5, and level 4 increases to level 6. Subgroup 6B outlines the conditions in which level 5 may increase to level 6.

*Pursuant to 8.600.4 definitions;
"Extreme Safety Risk to Self" means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client: A. Displays self-destructiveness related to self-injury, suicide attempts or other similar behaviors that seriously threaten the Client's safety; and,
B. Has a rights suspension in accordance with Section 8.604.3 or has a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits the ability of the Client to harm himself or herself.
"Public Safety Risk-Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has: A. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and, B. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised. "Public Safety Risk-Not Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:
A. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,
B. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

8.612.4 Support Level Review Process [Eff. 2/1/12]

A. The clientMember, his or hertheir legal guardian, or their legally authorized representative, family member, or CMA, as appropriate, may request a review regarding the of the Support Level assigned when there isthey have reason to believe it does not to meet the clientMember's needs.

B. The When a Support Level Review (SLR) is requested, the CMA shall complete the informationSLR request in a manner determined by required by the Department on the Department's prescribed request form. to request that the clientMember's assigned Support Level be reviewed. Once the SLR request form is completed, Prior to submitting the request, the CMA shall provide an opportunity for the clientMember, his or hertheir legal guardian, or their legally authorized representative, or family member, as appropriate, to review the request and provide additional information prior to submissionthat will be submitted to the Department for review.

C. The Department shall convene a review panel to examine Support Level Rreview requests monthly or as needed.

1. The review panel shall be comprised of the following:

a. A minimum of three (3) members designated by the Department.

b. Members shall include staff from the Department, ~~staff from a CMA that does not provide services to the client,~~ with extensive knowledge and experience with the SIS assessment, the Support Levels, case management, and HCBS waiver services.

2. The review panel:

a. Shall examine all of the information submitted by the CMA and seek to identify any significant factors not included in the Support Level calculation, which cause the ~~client~~Member to have substantially higher support needs than those in the established Support Level.

b. In cases where the panel finds that the ~~client~~Member does have substantially higher support needs than those in the initial Support Level, the panel may assign the ~~client~~Member to a Support Level that is a closer representation of the ~~client~~Member's overall support needs.

3. A ~~client~~Member who has been assigned to a higher Support Level shall have this assignment re-examined by the review panel at least annually or at a greater or lesser frequency~~as~~ determined by the Department.

a. The CMA shall submit a SLR request to have the Member's Support Level re-examined no later than thirty (30) ~~-~~days prior to the end date determined by the department.,

b. The ~~unless the~~ panel may determine~~s~~ that the ~~client~~Member's condition necessitating a higher Support Level is unlikely to improve and, therefore; does not require a re-examination.

D. The Department shall provide the CMA and the ~~client~~Member, ~~his or her~~their legal guardian, or their legally authorized representative~~, or family member, as appropriate,~~ with the written decision regarding the requested review of the ~~client~~Member's Support Level within fifteen (15) business days after the panel meeting. The written decision notification shall include the date of the SLR request, the Support Level determination, the effective and the end date of the increased Support Level~~,~~ and, if denied, the reason for denial of an increased Support Level.

1. The results of the panel review for a ~~client~~Member enrolled in the HCBS-DD waiver are conclusive.

2. If a ~~client~~Member enrolled in the HCBS-SLS waiver, ~~his or her~~their legal guardian, or their legally authorized representative~~, or family member, as appropriate,~~ disagrees with the decision provided by the panel, the ~~client~~Member, their legal guardian, or their legally authorized representative may request a review by the Department's Executive Director or ~~his or her~~their designee, within fifteen (15) business days after the receipt of the decision.

a. The Department's Executive Director, or ~~his or her~~their designee, shall review the request and provide a written decision within fifteen (15) business days.

b. The decision of the Department's Executive Director, or ~~his or her~~their designee, shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.

3. The CMA shall make any necessary PCSP and PAR revisions resulting from the Support Level changes, within 10 business days of receipt of approval or denial of the SLR request.

E. The ~~client~~Member shall be notified, pursuant to the Department of Health Care Policy and Financing rules in Section 8.057.2.A when a waiver service is terminated, reduced, or denied. At any time, the ~~client~~Member may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3.A.

8.612.5 Definitions

A. "Extreme Safety Risk to Self" means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client:

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

2. Has a rights suspension in accordance with Section 8.604.3 or has a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits the ability of the Client to harm himself or herself.

B. "Member" has the same meaning as the terms "Member" and/or "Client" as defined in Sections 8.500 and 8.500.90

C. "Public Safety Risk-Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

1. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,

2. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

D. "Public Safety Risk-Not Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

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

2. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 22-12-28-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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 22-11-08-A, Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000.

3. This action is an adoption of: new rules

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*

Insert the newly proposed text at 8.8000. This rule is effective April 14, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 22-12-28-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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).

   Create rules to administer the Rural Provider Access and Affordability Stimulus Grant Program established through the enactment of Senate Bill 22-200 including a methodology to determine which rural providers are qualified for grant funds, permissible uses of grant money, and reporting requirements for grant recipients.

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:

   American Rescue Plan Act of 2021 (ARPA), Public Law 117-2

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   Section 25.5-1-207 (5), C.R.S. (2022)

Initial Review
Proposed Effective Date **03/30/23**
Final Adoption **02/10/23**
Emergency Adoption

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 22-12-28-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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.

   Colorado hospitals in rural communities and their associated clinics will benefit from the proposed rule by helping these providers modernize their information technology systems which tend to lag behind their urban and suburban counterparts. Residents of rural Colorado will benefit as the program will support reducing health care costs in communities, add jobs, stimulate the economy, improve access to care, and mitigate rural health disparities.

   The funding for the Rural Provider Access and Affordability Stimulus Grant Program comes from federal funds with no cost to the state or local communities.

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

   The Rural Provider Access and Affordability Stimulus Grant Program will drive financial sustainability for hospitals and clinics in rural areas of Colorado by investing $9.6 million in health care affordability and health care access related projects:

   - $4.8 million in health care affordability projects, such as shared analytics platforms, telehealth supports, and enabling shared care management between rural providers

   - $4.8 million in health care access projects, such as extending hours for primary and behavioral health care, telemedicine including remote monitoring supports, new or expanded access sites including surgery, chemotherapy, and advanced imaging

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 General Assembly appropriated $400,000 to the Department to administer the Rural Provider Access and Affordability Stimulus Grant Program when it enacted Senate Bill 22-200. These funds are sufficient to administer the program and no

costs to other agencies are expected. The funds for the Rural Provider Access and Affordability Stimulus Grant Program are federal funds from the American Rescue Plan Act of 2021 (ARPA) and there is no impact on state revenues.

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

   Adopting the proposed rules to administer the Rural Provider Access and Affordability Stimulus Grant Program will allow the Department to grant $9.6 million of federal funds to rural providers as directed by the General Assembly to improve health care affordability and access and stimulate the economies in rural Colorado.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, 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.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no less costly or intrusive methods for achieving the purpose of the proposed rule.

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.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no alternatives to rule making than the proposed rule. The proposed rule includes those elements necessary to administer the grant program and were developed and supported by the Rural Provider Access and Affordability Advisory Committee established by the legislation.

8.8000 Rural Provider Access and Affordability Stimulus Grant Program

8.8001 PURPOSE AND LEGAL BASIS

Pursuant to C.R.S. § 25.5-1-207, the Rural Provider Access and Affordability Stimulus Grant Program provides grants to qualified providers to improve health care affordability and access to health care services in rural communities and to drive financial sustainability for rural hospitals and clinics.

8.8002 DEFINITIONS

A. Advisory Committee means the rural provider access and affordability advisory committee as defined in section 25.5-1-207 (3), C.R.S.

B. Department means the Colorado Department of Health Care Policy and Financing.

C. Health Care Access Project means a project that expands access to health care in Rural Communities including but not limited to:

1. Extending hours for access to primary care or behavioral health services,

2. Investing in dual track emergency department management,

3. Expanding access to Telemedicine including remote monitoring support,

4. Providing new or replacement Hospital beds,

5. Expanding access to long term care and recovery care in skilled nursing facilities, and

6. Creating or expanding sites that provide surgical care, chemotherapy, imaging, and advanced imagining including computerized tomography scans.

D. Health Care Affordability Project means a project that modernizes the information technology infrastructure of Qualified Rural Providers including but not limited to:

1. Creating a shared analytics platform and care coordination platforms among Qualified Rural Providers, and

2. Enabling technologies, including telehealth and e-consult systems, that allow Qualified Rural Providers to communicate, share clinical information, and consult electronically to manage patient care.

E. Hospital means a hospital licensed or certified pursuant to section 25-1.5-103 (1)(a), C.R.S. or an affiliate owned or controlled as defined in section 25.5-4-402.8 (1)(b), C.R.S., by the hospital.

F. Qualified Rural Provider means a Hospital located in a Rural Community in Colorado that has a lower net patient revenue or fund balance compared with other Rural Hospitals~~.~~.

G. Rural Community means a county with a population of fewer than fifty thousand residents; or a municipality with a population of fewer than twenty-five thousand residents if the municipality is not contiguous to a municipality with a population of twenty-five thousand or more residents.

H. Rural Stimulus Grant means funding received from the rural provider access and affordability grant program established in section 25.5.1-207, C.R.S.

I. Telemedicine means the delivery of medical services as defined at section 12-240-104 (6), C.R.S.

8.8003 GRANT AWARD PROCEDURES

A. Rural Stimulus Grants will be awarded through an application process.

1. A request for grant application form shall be issued by the Department and posted for public access on the Department's website at https://hcpf.colorado.gov/research-data at least 30 days prior to the application due date.

2. A Qualified Rural Provider may submit applications for more than one project or may submit a joint application with another Qualified Rural Provider.

3. The application will include:

a. Project overview.

b. Proposed budget including:

i. Total funds requested not to exceed $650,000 per project per applicant,

ii. Itemized direct expenses,

iii. Indirect expenses limited to federal Negotiated Indirect Costs Rate Agreement (NICRA) or de minimis rate of 10 percent if the applicant does not have an NICRA,

iv. If applicable, documentation of quotes or estimates for construction, equipment, or other expenditures, and

v. If applicable other sources of funding that will be utilized to complete the proposed project.

c. Project timeline to commence no earlier than July 1, 2023 and to conclude no later than December 31, 2026.

d. Description of Qualified Rural Provider's diversity, equity, and inclusion strategy and how diverse community needs are met by the project.

e. Demonstration of financial need.

i. Qualified Rural Providers in the bottom 40% of net patient revenues for the three-year average of 2016, 2017, and 2018 or the bottom 6% fund balance for 2019 as determined by the Department's review of CMS 2552-10 Medicare Cost Reports are considered to meet the financial health requirement.

ii. Other Qualified Rural Providers may submit additional financial supporting information to support their financial need.

f. For capital investment projects, facility or equipment age.

g. Impact to health care affordability or access to care.

i. Statement of need outlying underlying problem the funding will address.

ii. Description of how the project's goals and objectives will be sustained after the Rural Stimulus Grant funds have been expended.

iii. Description of how the project will increase access to specialty care, if applicable.

iv. Description of how project will improve care coordination, if applicable.

v. Description of partner engagement, if applicable.

B. The Advisory Committee will review Rural Stimulus Grant applications and recommend Rural Stimulus Grant awards to the Department's executive director based on the following criteria:

1. Budget and financial need.

2. Partner collaboration, support, or engagement.

3. Completeness of response.

4. Ability to execute and complete project.

5. Reasonableness of timeline.

6. Diversity, equity and inclusion and how diverse communities will be impacted by the project.

7. County Medicare and Medicaid caseload percentage of population.

8. Statement of need.

9. Sustainability of project.

10. Impact to health care affordability or access to care.

C. The Department's executive director or his or her designee shall make the final Rural Stimulus Grant awards to Qualified Rural Providers.

1. The total funding for Rural Stimulus Grants is limited to no more than $9.6 million with no more than $4.8 million for Health Care Access Projects and no more than $4.8 million for Health Care Affordability Projects.

2. The Department may change Rural Stimulus Grant amounts depending on the final number of Rural Stimulus Grants awarded, the availability of Rural Stimulus Grant funds, or the goals stated in the Rural Stimulus Grant application.

3. Rural Stimulus Grant applicants may request reconsideration of Rural Stimulus Grant awards within 5 business days of award notification in writing to the Department's executive director. The executive director will respond to the request for reconsideration within 10 business days of receipt.

4. The Department will execute a grant agreement with each Rural Stimulus Grant recipient.

D. The Department will disburse Rural Stimulus Grant funds no earlier than July 1, 2023 and no later than July 1, 2024. Any money not disbursed by July 1, 2024 will revert to the Economic Recovery and Relief Cash Fund created pursuant section 24-75-228 (2)(a), C.R.S.

E. Rural Stimulus Grant recipients will expend Rural Stimulus Grant funds by the timeline in their grant agreement and no later than December 31, 2026. Any Rural Stimulus Grant funds not expended by Rural Stimulus Grant recipients by December 31, 2026 will be recovered by the Department to be returned to the U.S. Department of the Treasury.

8.8004 PERMISSIBLE USES OF GRANT AWARDS

A. Rural Stimulus Grant funds must be used for Health Care Affordability Projects or Health Care Access Projects to improve health care affordability and access in Rural Communities.

B. Rural Stimulus Grant funds may not be deposited into a pension fund and may not be used to service debt, satisfy a judgment or settlement, or contribute to a "rainy day" fund.

8.8005 REPORTING REQUIREMENTS FOR GRANT RECIPIENTS

A. Recipients of Rural Stimulus Grant funds for capital expenditures must submit a written justification as set forth in 31 Code of Federal Regulations 35.6 (b)(4) to the Department.

B. For the duration of the grant agreement, Rural Stimulus Grant recipients must submit a quarterly report to the Department no later than the 10th day of the month following the end of each quarter including but not limited to a brief narrative and itemized expenditure and performance metric data.

C. Rural Stimulus Grant recipients will submit a final report to the Department within 30 calendar days following the end of the grant agreement including an overall narrative and itemization of all expenditures and performance metric data for the total Rural Stimulus Grant award.

8.8006 RECORD RETENTION AND ACCESS

A. Rural Stimulus Grant recipients must maintain records of expenditures for a minimum of five years after funds have been expended or returned to the Department, whichever is later.

~~A.~~B. Rural Stimulus Grant recipients must allow the Department and state and federal auditors access to records related to the expenditure of Rural Stimulus Grant funds.